STATE OF INDIANA)
) SS:
COUNTY OF DELAWARE)

IN THE DELAWARE COUNTY SUPERIOR COURT

CRAIG DUNN and PHILIP WILEY, et al.,)
Plaintiffs,)
)
-v-) CAUSE NO.
) 18D01-9305-CT-06
RJR NABISCO HOLDINGS CORPORATIONS, et al.,)
Defendants.)

VOLUME II
MORNING SESSION

The deposition upon oral examination of NICKI C. TURNER, M.D., a witness produced and sworn before me, Patrice E. Morrison, RMR-CRR, Notary Public in and for the County of Marion, State of Indiana, taken on behalf of the defendants at the offices of Medical Consultants, 2525 University Avenue, Muncie, Indiana, on November 4, 1997, at 9:20 a.m. pursuant to the Indiana Rules of Trial Procedure.

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ALSO PRESENT:
Mark Dudley

I N D E X

INDEX OF DEFENDANTS' EXHIBITS

NICKI C. TURNER, M.D.
having been first duly sworn to tell the truth, the whole truth, and nothing but the truth took the stand and testified as follows:
DIRECT EXAMINATION CONTINUING
BY MR. OHLEMEYER:
Q. Dr. Turner, we're here today to continue your deposition. You understand you're still under oath?
A. Yes, I do.
Q. All right. If you don't understand a question I ask you, will you let me know?
A. Yes, I will.
Q. Does the phrase "diagnosis of exclusion" mean something to doctors? Is it a term of art?
A. The diagnosis of exclusion.
Q. A diagnosis of exclusion.
A. To exclude a diagnosis, is that what you're asking?
Q. Well, Doctor, I'm asking if the phrase "a diagnosis of exclusion" has any specific meaning to you.
A. Well, we exclude diagnoses. Excluding a diagnosis means you're going through the

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differential and deciding what fits with the clinical history, the clinical presentation versus what does not.
Q. And is what you're left with a diagnosis of exclusion?
A. I don't normally use that term. I use excluding diagnoses.
Q. But have you heard other doctors use that term?
A. Not really.
Q. It's not a phrase that has any meaning to you.
A. If you turn the words around, yes, it does. If you don't turn the words around, it's kind of confusing.
Q. Would you define what the word "impression" means as it's used in medical records?
A. Impression means that, what we feel would be the most likely diagnosis. At least, I mean, we put impressions such as atherosclerotic cardiovascular disease, hypertension, diabetes, possible neoplastic syndrome.
Q. How does an impression compare to a pathological diagnosis?

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A. Impression is somewhat of a preliminary -- it could be or could not be a preliminary -- it's essentially what you've done is you've examined the patient, taken a clinical history, looked at all lab work, at least the lab work that's presented to you when you see the patient, and then make your impressions.
A diagnosis -- is that what you're asking? A diagnosis is when something is much more reproducible or much more documented.
Q. For example, in the context of a bronchoscopy, if you were the doctor involved in performing that procedure, you would record specific impressions you might have formed as a result of that procedure, and then send the tissue down to the pathology lab so they could diagnose it pathologically.
A. Yes. You would wait for the pathological diagnosis. My impression would be possibly an endobronchial lesion, and the primary diagnosis would have to wait for the cytology.

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Q. So the role the pathologist plays in managing a patient's care is to help confirm your impressions. Or -- well, you tell me. I mean, is that --
A. The pathologist looks at the tissue, confirms or excludes what our -- what our impressions are.
Q. All right. Tell us, Doctor, when did you first reach your opinion about the cause of Mrs. Wiley's cancer?
A. I would have to look at the records. Why don't you give me the records.
Q. Well, why don't you do that.
A. When we decided that this was an adenocarcinoma is when the transthoracic biopsy was completed.
Q. My question, Doctor, is when did you, Dr. Turner, come to the conclusion or reach the opinion that Mrs. Wiley's cancer was caused by exposure to environmental tobacco smoke?
A. That was different from your first question. Your first question was -- first question was when did I make the diagnosis what was causing her lung cancer.

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Q. You must have misunderstood me, Doctor. My question is when did you, Dr. Turner, reach the conclusion or come to the opinion about what caused Mrs. Wiley's lung cancer?
A. When I first saw her, first of all, she had a right lower lobe collapse and she had an abnormality of her chest x-ray. She also had a, what appeared to be a process that was eating away her bones in the back and her lumbar spine. Therefore, my concern was there was some type of neoplastic process occurring.
When we did the CT scan, she showed that there was -- the CT scan revealed that there was a mass in her right lung and, therefore, my concern was a lung cancer.
When I initially talked with her, she had stated, in my admission note here, that she had been exposed to secondhand smoke. Obviously, when I talked to her about whether she was a primary smoker or not she said no. And then I was talking to her about her other history and, as I do, I talk to people about exposure to secondhand smoke or any other problems such as drinking and

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everything else. So she had been exposed to secondhand smoke. In my mind, that increases her risk of lung cancer.

So what I did is proceeded to that diagnosis -- to rule out that diagnosis or rule in that diagnosis, and that's when we proceeded to do the bronchoscopy. And subsequent to that we had to do a transthoracic biopsy, which diagnosed adenocarcinoma, and it was at that point that I felt that, from the presentation of the bronchoscopy and from the diagnosis and from her clinical presentation, that this was related to secondhand smoke.

Q. And my question, Doctor, is when did you come to that conclusion? Can you put a date on it for me?

A. Well, from -- not really. It was from the time she was admitted to the time she died.

Q. Well, did you suspect or believe that Mrs. Wiley's health problems were smoke-related on the day that you took the history from her?

A. What I say here, "rule out persistent cough with hemoptysis," I was concerned that she

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had lung cancer. That there was something going on with her.

Q. But -- and I understand that deals with diagnosing or establishing what medical problems Mrs. Wiley had. My question, Doctor, deals with the cause of those problems.

Was that the point where you determined in your mind or came to the conclusion that Mrs. Wiley's health problems were related to her prior claim of exposure to environmental tobacco smoke?

A. It was probably in the latter part of her hospitalization when I had examined her a number of occasions, repeated the -- correction, completed the other diagnostic studies such as the CT, the bronchoscopy, and as we worked through the diagnosis. So it was probably towards the latter half of her hospitalization is specifically when we definitively were able to come up with a cell type.

Q. So Dr. Turner, do you recall telling Mr. Wiley on the day that you took the admission history from Mrs. Wiley that her

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problems were smoke-related?

A. I do not recall whether I did or not.

Q. Is it, knowing what you know about your treatment and the chronology of events with Mrs. Wiley, is it possible you would have told him that?

A. I can't tell you whether I did or not.

Q. If Mr. Wiley told us you told him that, do you think he's mistaken?

A. If Mr. Wiley told you that, then he's probably correct.

Q. So then is it fair to say, Doctor, that as early as the date you took the history from Mrs. Wiley you had come to the conclusion or formed an opinion that her health problems were smoke-related?

MR. CROSS: I'll object to the question, that's been asked and answered; you just asked her that question, she answered as best she could. You're restating the testimony and asking her to disagree with herself. It's an unfair question.

MR. OHLEMEYER: I hope, Mr. Cross, we don't have speaking objections like that

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the rest of the day designed to help the witness answer the question.

MR. CROSS: So do I.

Q. My question to you, Dr. Turner, is it, as you think back on this, is it possible that you formed an opinion on the date you took the history, the admission history from Mrs. Wiley that her health problems were related to exposure to environmental tobacco smoke?

MR. CROSS: Objection. Asked and answered.

THE WITNESS: Do I answer that?

MR. CROSS: Yes.

A. The thing is, when you're taking a history, you're going through a differential diagnosis. And when I took the history, she had been exposed to secondhand smoke. When I saw her, this lady was not a primary smoker, there was a destructive lesion of her lumbar spine, she had an abnormal chest x-ray. Obviously, that was -- the question in my mind was it's a possibility but it was not definitive.

I'm going through the differential.

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I'm going through just like any good physician would do. I'm looking at all the factors or else I would not be a good physician. I look at the differential, examine the patient, reexamine the patient, make sure everything fits together. That was the only way to do this.

And I've essentially answered your question. I can't tell you whether I spoke to him or not about that. I can tell you, when I took the history and put it in my H&P, that would increase my suspicion that possibly this was, but until I make a definitive diagnosis I'm not going to put that down.

Q. Well, my question is, notwithstanding what you wrote in the medical record, do you recall coming to the conclusion or telling Mr. Wiley that you believed his wife's problems were smoke-related?

MR. CROSS: Objection, asked and answered.

A. As I already told you, I do not recall. I mean, I don't know what you want -- I'm not going to lie to you. If it's not in my

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notes here and it's not in my notes here, how am I supposed to remember that?

Q. "Here" being the handwritten progress notes --

A. Yes.

Q. -- and the dictated admission note?

A. Yes.

Q. Those are the best source of the most accurate information you have about the diagnosis or treatment of Mrs. Wiley.

A. I mean, what else is there right now? I mean, when I --

Q. Well, I don't want to interrupt you but there's your recollection. My question to you, Doctor, is, are you telling me that these records that you've referred to, the written progress notes and the typed dictation, are the best and most complete record of what happened at the time it happened with respect to Mrs. Wiley's diagnosis and treatment?

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the diagnosis given the clinical presentation, given the clinical diagnosis, and the data that we had at that time.

Q. Is it possible, Doctor, that you concluded as early as May 30th, 1991, that Mrs. Wiley's health problems were smoke-related?

A. It's possible that as early -- well, the point is, is that I repeated the CT scan, I'm trying to decide how to explain a nonsmoking lady that has a large lung lesion, that is metastatic, and so when I'm going through the differential diagnosis, again, I'm attempting to define why she would have this happen to her.

Q. Well, let me ask you this: On May 30, what's the basis of your statement that she had a large lung lesion?

A. Have to look at the chest x-ray.

Q. Well, but hadn't the bronchoscopy been done?

A. Well, the bronchoscopy apparently had been done by Dr. Patel.

Q. And it was negative?

A. Yes.

Q. So there was no --

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A. Supposedly it was negative. You have to ask him whether it was negative or not.

Q. The x-ray, was the x-ray that was available to you on May 30th diagnostic of a large lung lesion? Let me withdraw that question, ask you another one.

Regardless of what I do or don't ask Dr. Patel, you recorded the fact that the bronchoscopy was negative for malignancy in your notes, didn't you?

A. The bronchoscopy was negative for maligancy in my notes? Could you define where that is?

Q. Well, look at your entry for 5/30. That's your admission entry, isn't it?

A. Yes.

Q. See at the bottom of the page, "bronc per Dr. Patel 5/91 - all negative"?

A. Yes.

Q. So the bronchoscopy that Dr. Patel performed prior to Mrs. Wiley's admission to Ball Memorial was negative for malignancy?

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what he put in his notes.
Q. Well, did you have any -- I mean, are you telling us that Dr. Patel didn't adequately or properly perform the bronchoscopy or record his findings?
A. I'm telling you that when he wrote his note I'm taking it at his word that that is negative. Unfortunately, that does not concur with what I was seeing, with what the chest x-ray showed, what the CT scan showed, and what subsequently, one month later, the autopsy showed.
Q. Well, we're not a month ahead of ourselves here. Let's talk about the time Mrs. Wiley comes to you. The only evidence you have of a large lung mass, as you've described it, is a chest x-ray that is suspicious for a mass; right?
A. It says there's a prominent right hilum with distal opacification in the right upper and middle lobes. Possibility of central tumor with distal pneumonia must be ruled out. There's volume loss noted with elevation of the diaphragm.
Q. So that x-ray could have been consistent

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with pneumonia; right?
A. A simple pneumonia with a lady that's been bringing up blood for six months? And that's had a persistent cough and that now has a metastatic or some type of lesion eating away her bone? That would not go along with a simple pneumonia.
You have to look essentially where the money is. With an abnormal chest x-ray and with the clinical history that she gave, a simple pneumonia would not be the most likely diagnosis.
Q. Well, how about an atypical pneumonia?
A. Doesn't matter. What type of atypical pneumonia are you saying?
Q. Doctor, all I'm telling you is what your record says and I'm asking you, the fact that Mrs. Wiley presented with a chest x-ray that revealed atelectasis of the right middle lobe with infiltrate involving the posterior segment of the right upper lobe isn't enough for you to diagnosis a lung cancer.
MR. CROSS: Counsel, what are you reading from?

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MR. OHLEMEYER: I'm looking at the doctor's 5/29 admission note.
Q. My question, Doctor, it really doesn't require any analysis of the record, my question to you, Is a chest x-ray that reveals atelectasis of the right middle lobe with infiltrate involving the posterior segment of the right upper lobe a sufficient amount of information for you to diagnose lung cancer in a patient.
A. You'd have to take the entire history.
Q. Well, did you diagnose primary adenocarcinoma of the lung in this woman based on that chest x-ray?
A. I've told you before that what you do is you look at the clinical presentation, you look at the presentation, you look at what clinical history you have. Just because -- I get patients all the time, and that's my job, I'm a critical care specialist, I get patients from other hospitals, and even from here, that they -- the diagnosis may be -- they're not -- they're not sure of the diagnosis, all they know is they can't answer the questions, they can't figure out

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why this patient is in trouble.
My job, as an intensivist and as somebody that deals with complex internal medicine problems is I look, and I tell my patients, when people get sent to me after being -- I've had patients that have been seen at the Mayo Clinic, I've had patients that have been other places and they come to me and say -- and the doctor sends them over and says "I don't know what's going on, would you please help me" and what I do is I start from the beginning.
I take the history, which is what I've done here, okay, I've essentially reiterated what they told me before, but it does not mean that I go down the same road. And I start over, I look at the patient, look at the clinical history, and what makes the most sense to that situation.
If this was atypical pneumonia, why would this lady have bone -- something eating away at her bones? Why would she be deteriorating? She's a 50 -- how old is she -- 56 years old. She's supposedly a healthy person, never had any other

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lesions that I have seen in the airway, primarily squamous, occur as the primary there and then they spread to other areas.
Q. Have you ever seen an adenocarcinoma primary -- a primary endobronchial adenocarcinoma?
A. No, I have not. In my experience, no.
Q. So if this is, indeed, in this case a primary adenocarcinoma that presented in the bronchus, it would be a first in your experience.
A. In my experience, yes. Usually these are squamous cell carcinomas.
Q. The majority of adenocarcinomas that are found primary to the lung are found in the periphery of the lung; isn't that right?
A. Primary in the lung are usually found in the periphery.
Q. And do you know what percentage of adenocarcinomas that metastasize in the lung are found in the bronchus?
A. I'm not aware there are any, but it's always a possibility, but I am not aware of any.
Q. Well, not in your experience? You're not suggesting it's medically impossible or not

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reported, are you?
A. If it's reported I have not read it.
Q. Doctor, can tumors in the periphery of the lung grow towards the bronchus and compress the bronchus?
A. That usually presents a separate way. I mean, when I looked at this lung --
Q. I don't want to interrupt you, Doctor, but the question is, Can tumors that begin in the periphery of the lung grow towards the interior of the lung and compress the bronchus?
A. You would expect their presentation to be separate. When I looked down in there, there was a tumor in the airway itself. Usually when I have a patient that has an adenocarcinoma that presses in on the bronchus, it is pushing in. It is not in the airway itself.
Q. Can tumor in the hilar lymph nodes either grow into or compress the bronchus?
A. Yes.
Q. So Doctor, am I correct that, prior to June 6th, the primary site of Mrs. Wiley's cancer had not been determined?

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A. Prior to June 6th, the primary site of her lung cancer -- primary diagnosis of her lung cancer or what was your question?
Q. Well, let's take it that way. Had she been diagnosed with carcinoma of the lung prior to June 6th?
A. The suspicion was there that that's what we were dealing with. It had not been diagnosed.
Q. And prior to June 6th, had the histological type of cancer that Mrs. Wiley suffered from been diagnosed?
A. The histologic type.
Q. Let me rephrase the question. Prior to June 6th there had been a biopsy of a growth in her chest wall; isn't that right?
A. Yes.
Q. And that, the pathology from that biopsy suggested a poorly differentiated carcinoma, probably not squamous or small cell; right?
A. Yes.
Q. And then you, on June 5th, decided that the airway should be evaluated to help confirm or find the primary site of Mrs. Wiley's cancer; right?

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A. Well, myself as well as any other physicians on the case that I might have talked to.
Q. Well, but you signed the progress note on June 5th that said "need to evaluate airway to obtain biopsy cytology to help confirm primary site."
A. Yes.
Q. Why didn't you guys do that sooner?
A. Well, because this poor lady had been sick for some time. She had -- she was in pain, she had a lesion in her lower back which is extremely painful. The bone was being eaten away. And if there was an easier way to make the diagnosis, that's what you do. I mean, an easier way for the patient to make the diagnosis. There was a lesion, a very firm lesion on her chest wall and, therefore, that's what we did. You don't do a complicated procedure and put the patient through something if it's not indicated and we would not get some benefits from it.
Q. So there was a possibility that the diagnosis of the mass on the chest wall might have given you some information that would have led you to believe the primary

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source of that cancer was somewhere other than the lung. Is that what you're telling me?
A. The possibility that, if we biopsied that lesion on the chest wall, that it would give us another source of a primary, yes.
Q. What would you have looked for in order to rule out -- my question, really, I guess, you might have answered it, is, on May 29th, May 30th you have a woman who has an abnormal x-ray that you've told me, in great detail, leads you to suspect a cancer of the lung. My question to you is, is why wait a week to perform a bronchoscopy on that woman?
A. Well, because, again, this patient was in a lot of pain, we were hopeful -- and if you notice, also, that I was doing sputums to see if there's any chance that we could make the diagnosis without doing an invasive procedure. When you treat a patient, you do the least invasive first. And this happens all the time.
If I have a patient with an abnormal chest x-ray and they have a lymph node up in

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the supraclavicular fossa, I go there. I don't do a procedure -- or at least a good physician would not do a procedure that would be riskier, they would go for where the biopsy would be easily -- easiest found.
Q. So on June 6th you do the bronchoscopy; on June 10th you're still waiting for the pathology and the cytology from that bronchoscopy.
A. Let's look at the -- let's look where the cytologies are coming back and what the dates are on those. Do you have those with you?
Q. Well, why can't we just look at the notes, Doctor?
A. Because I don't write -- I mean, I look at the whole chart. I do not just write at the notes.
Q. Well, I've got a pathology report dated June 12, 1991, that says -- I'm sorry, that's the wrong one. That's from the fine needle --
A. Now, on the 10th of June -- I did the bronc on the 6th.
Q. Correct.
A. On the 10th of June we see that the slides

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were -- the date selected was 6/6, the date by Dr. House was 10 of June. The date received and the date on there was the 10th of June.
Q. All right.
A. So what was your question?
Q. My question is, What do the pathologists diagnose on the 10th of June?
A. As you can see on the pathology report, it says a few atypical cells from the right hilar mass. The next one is negative right hilar mass. The next one is sputum trap, which is body fluid, highly suggestive of squamous cell carcinoma.
So what they're saying is, is that these are atypical cells. One says negative, which is not unusual. A few atypical cells. And highly suggestive of squamous cell carcinoma.
Q. There's no pathological diagnosis of squamous cell carcinoma on June 10th.
A. It says a few atypical cells highly suggestive of squamous cell; it's not a diagnostic, no.
Q. Is one of the reasons -- and by the way, you

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could have obtained sputum samples without doing the bronchoscopy.
A. Well, sputum samples are very -- I mean, we can do, and we did do that, because, as you can see, one of these, I was trying very hard not to do any invasive procedures unless it was necessary to help this lady. That's what we always do. But it's unusual to be able to -- to be able to make a diagnosis, depends on whether she can cough effectively, how many secretions she's having, is the tumor shedding at that point in time.
Q. Which is all part of the reason why you do the bronchoscopy.
A. Yes.
Q. And the bronchoscopy, the biopsy material, tissue obtained from the bronchoscopy was non-diagnostic of squamous cell.
A. It was suspicious. You had a few atypical cells and you had a few cells highly suggestive of squamous cell carcinoma. It was not negative.
Q. But it was not positive. It was not diagnostic of squamous cell.

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A. It was suspicious for squamous cell carcinoma and there was also atypical cells.
Q. Now, in hindsight, of course, we know that this woman didn't have squamous cell carcinoma.
A. Yes.
Q. So as suspicious as that might have been, A, it wasn't diagnostic; and B, it didn't turn out to be correct. Did it?
A. No. Because we completed -- that's one of the reasons, if there was a diagnosis here, definitively diagnostic of squamous cell, we would have stopped at that point. It was not. Therefore, we proceeded to the transthoracic biopsy.
Q. Even though the patient was under no code status and was in a condition that prevented her from being managed at home.
A. Yes. We do that -- I mean, just because there are no code doesn't mean you don't care for them, you don't treat them. We have a number of patients that are no code, but you still don't -- you don't give up all hope.
Q. If Mrs. Wiley did, indeed, have a

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bronchogenic carcinoma, cancer of the lung, on June 10th there certainly would be a limited prognosis for her survival.
A. Depends on the type of cell. I mean, again, what we were trying to do is give this lady some more time and that's one of the reasons why we were still looking.
Q. What cell type would have given you -- what cell type, in your opinion, would have presented a less limited prognosis if this, indeed, were a bronchogenic carcinoma?
A. Well, the only cell type that would possibly be would be a small cell, or an oat cell.
Q. So just so I make sure I understand the question and the answer, if Mrs. Wiley had a small cell, or an oat cell, carcinoma and you could demonstrate that on June 10th, then you believed her prognosis would be better than if she had an adenocarcinoma or a squamous cell carcinoma.
A. If she was amenable to therapy, it's a possibility we might have been able to give her some additional time. It depends on how she would have responded. It depends on the tumor load.

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Q. But all things being equal, you were looking for information about the histology because, am I correct, in your opinion, if you had found that it was a small cell or, as you've described it, an oat cell carcinoma, you would be more optimistic about the potential for treatment.
A. This lady had a large tumor mass. We were hopeful, just to give her some semblance of hope, and we would not have gone on without discussing the case.
I mean, there was several physicians on this case. Dr. Songer -- if Dr. Songer felt that most likely there was no hope -- but I've worked with him on a number of cases and we just don't do that to patients.
Q. Well, I understand that, Doctor, but my question is, all things being equal, when you're waiting for these pathology results, are you more or less encouraged by a pathological diagnosis that indicates you're dealing with a small cell carcinoma as opposed to a squamous?
A. If it was this small cell carcinoma, that would possibly increase her ability to

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respond to some extent to some type of chemotherapy regimen or radiation. Again, I'm not an oncologist, but in my experience, I mean, when you have a patient that is this ill, you try to do the best you can for that patient.
Q. By June 11th then, there is still not a histological diagnosis of adenocarcinoma.
A. No.
Q. And by June 14th, there is an indication that one of the pathologists thinks it's an adenocarcinoma but another pathologist thinks it looks more like a squamous cell carcinoma; right?
A. I think there were two pathologists that thought it was diagnostic of an adeno, and one -- I have to find that. Do you have that sheet with you?
Q. June 14th, your note.
A. After talking with Dr. Baldwin -- obviously, he was going to clarify that.
Q. Let me stop you there. Did Dr. Baldwin ever clarify that for you, that discrepancy among the diagnoses? For the record, Doctor, you're now referring to the pathology

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report; right?
A. Yes.
Q. What I'd really prefer you to do is to take a look at your note and tell me what you knew on June 14th.
A. June 14th it says, "discussed case with Dr. Baldwin calling transthoracic adeno but reportedly chest wall looked more like squamous cell carcinoma. He will look into this discrepancy and clarify."
Q. Let's start right there. Did he ever clarify that for you?
A. Well, oftentimes a pathologist -- and you could -- you need to ask him, obviously. But a pathologist will make a dictation on a note rather than write in the chart.
Q. Right. So what is -- my question is, did he ever look into that discrepancy and clarify it for you?
A. Well, it says here, "The previous surgical --"
Q. "Here" being what?
A. This pathologist's report of the 12th. Date 12th of June. It says, "The previous surgical of a chest wall mass on this

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patient is noted. This has Ball Hospital No. 5534-91. Slides from the previous surgical were reviewed. In addition slides from this fine needle aspiration and the previous surgical were seen by Dr. Sandquist and Brown. All of us agree that the chest wall tumor and the tumor from the lung fine needle aspiration appear to be the same. Dr. Sandquist and myself favor a diagnosis of adenocarcinoma. Dr. Brown favors a diagnosis of poorly differentiated carcinoma."
Q. And my question to you, then, is, did Dr. Baldwin ever look into that discrepancy and clarify it for you?
A. He most likely did or I wouldn't have put that on the diagnosis.
Q. Why in your notes do you record the clarification from Dr. Baldwin?
A. Well, this is -- this note here from the pathology department I believe is clarification. You could ask him specifically.
Q. But, see, the reason I'm asking, Doctor, is that's dated June 12 and your note is dated

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June 14. So two days after the path report you say that Dr. Baldwin is going to look into the discrepancy and clarify it. I want to know if he ever did that for you.
A. I can't recall.
Q. Okay. Now, at the point in time where Mrs. Wiley died, did you believe that she suffered from a primary adenocarcinoma of the lung?
A. At the point that she died, did I believe that she suffered from a primary adenocarcinoma of the lung. Yes, I did.
Q. Is there any other doctor who records or describes or shares that opinion that you can point to in these medical records?
A. In the notes? If they did not note it on this record, I cannot tell you that. Although, it often happens that physicians will continue to follow a patient in the hospital, may not always make notes. We talk about patients.
Q. Okay. So the answer to my question, though, is that you are the only doctor who has recorded an opinion in these medical records that Mrs. Wiley suffered from an

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adenocarcinoma of the lung, a primary adenocarcinoma of the lung.
A. That is noted in these medical records, it apparently is so.
Q. Then let me go on further. In your death summary which was dictated 7/21-24/91, you go so far as to say Mrs. Wiley's cause of death was metastatic adenocarcinoma of the lung secondary to secondhand smoke. So my question to you, Doctor, is when did you reach that opinion?
A. Well, when we obtained the biopsy, the transthoracic biopsy, that was consistent with adenocarcinoma according to two pathologists.
Q. But at that point in time, how did you know that that adenocarcinoma was primary as opposed to metastatic to the lung?
A. Because, given the clinical presentation, what I saw at the time of bronchoscopy, that's the only diagnosis that would make sense.
Q. All right. Then what is the basis of your conclusion that her metastatic adenocarcinoma of the lung was secondary to

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secondhand smoke? Let me ask you a better question first.

What do you mean by secondary in that sentence?

A. That means that I felt that secondhand smoke was the primary cause of her lung cancer.

Q. Tell me what the basis of that opinion was on July 21, 1991.

A. Well, from the clinical presentation, from the fact that this tumor was arising from the bronchus, that this lady was a nonsmoker, non-primary smoker, the fact that she had been exposed to secondhand smoke, the fact that she had metastatic lesions to the bones, the fact that there was no other -- her breast examination was negative, her CT of her abdomen revealed no evidence of primary pancreas or primary liver or renal cell carcinoma. Nothing else made sense. That was the only diagnosis that I could come up with at this point.

Q. The clinical presentation doesn't in and of itself suggest or indicate to you what caused that woman's cancer, does it?

A. The clinical presentation, you're talking

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about her history and physical examination?

Q. Well, my question, I guess, is this: If you find primary adenocarcinoma of the lung in a nonsmoker who says that he or she had been exposed to environmental tobacco smoke, is that all the information you need to determine that that cancer was secondary to secondhand smoke?

A. I think if I -- in my opinion, if I know someone has exposure to secondhand smoke, it depends on the amount of exposure, whether they had any other type of factors that would have favored some other etiology, then I would have to take that into consideration as the possible etiology given the history that we know.

I mean, if I have a patient that's drinking two pints of whiskey a night and they have cirrhosis, you know, you look at cause and effect, what the --

Q. Well, Doctor, suspicions --

A. Suspicions are --

Q. I don't mean to interrupt you.

MR. CROSS: Let her finish her answer.

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Q. What you have here is a tumor that, for the first time in your career, you believe to be an adenocarcinoma arising in the bronchus, in a woman who claims to have been a nonsmoker exposed to environmental tobacco smoke, and you now have for the first time ever, I take it, concluded that you have a patient with a metastatic adenocarcinoma of the lung secondary to secondhand smoke.

A. That's not true.

Q. What's not true about it?

A. The point is --

Q. Doctor, excuse me, what's not true?

MR. CROSS: Let her finish her answer, counsel.

Q. What's not true about the statement I just made?

A. Okay. Let me restate that statement, okay? What you're asking is, is this correct, the fact that I have a 56-year-old female that has been exposed to secondhand smoke, has a bronchial carcinoma consistent with adenocarcinoma that was diagnosed by a pathologist and I made the diagnosis of secondhand smoke as a causative etiology.

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Is that your question?

Q. Yes. Let's just take it one at a time. Had you ever diagnosed secondhand smoke as a causative etiology prior to July of 1991?

A. I have had a number of cases that I have been extremely suspicious. We have patients that their husbands or wives smoke around them -- let me finish. That they are exposed either to some of the factories around here, to secondhand smoke, such as Warner Gear, I have been extremely suspicious that their cancers were related to secondhand smoke since there was no other factors possible.

Q. Had you ever dictated a death summary prior to July 21, 1991, where you attributed the cause of death to metastatic adenocarcinoma of the lung secondary to secondhand smoke?

A. I cannot tell you whether I did or not.

Q. Well, do you think you did?

A. I can't. I can't tell you whether I did or not.

Q. And prior to July of '91 you had never seen a primary adenocarcinoma of the lung present in the bronchus.

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A. No.
Q. Prior to July of 1991, what effort had you made to investigate or obtain information about other potential risk factors for lung cancer that Mrs. Wiley might have encountered in her life?
A. Prior to June of '91.
Q. July of '91.
A. Well, she was admitted on June 29th, so I had her history, there was a couple of days there. Since I had just met her, I have to take her word, as well as her husband, whatever they gave to me during her hospitalization as to the risk factors that would be involved in her lung cancer.
Q. So you're not telling us, Doctor, are you, that there is nothing else that could have caused Mrs. Wiley's lung cancer. I think what you're telling me is, based on the information you had available to you and what you believe to be the situation at the time, you attributed her lung cancer to what you believed to be the most likely cause.
A. In her presentation -- let me restate your question. In her presentation, with an

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endobronchial lesion, an adenocarcinoma, secondhand smoke exposure, no other factors that I could come up with to cause this presentation, that is the only diagnosis that I could come up with.
Q. But my point is, is that doesn't necessarily mean that something else couldn't have caused this.
MR. CROSS: Objection, asked and answered.
MR. OHLEMEYER: Let me rephrase it.
Q. The fact that you find lung cancer in a nonsmoking woman who claims exposure to secondhand smoke, does or does not that exclude the possibility that something else might have caused that cancer in your opinion?
MR. CROSS: Same objection.
A. When we look at a patient, and we look at the factors that may be causing this, what you do is you look at percentages. If this patient -- if I had another woman, or another man, or whoever came in to me and has a primary lung carcinoma and they have been exposed to secondhand smoke, and I

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cannot -- there are no other precipitating factors, I would be extremely suspicious that was the cause.
Q. If Mrs. Wiley had presented with a primary adenocarcinoma of the lung, but you didn't have any information about her history, would the fact that she had a primary adenocarcinoma of the lung give you enough information to determine what caused her disease?
A. No.
Q. So is it fair to say, Doctor, that you can't have and don't have -- you couldn't have reached an opinion about Mrs. Wiley's -- about the cause of Mrs. Wiley's cancer without some information about her history.
A. Yes.
Q. Okay. What effort did you make, beyond what's recorded in these medical records that you've produced to us, to obtain an accurate and complete history of Mrs. Wiley's possible exposure to risk factors for lung cancer?
MR. CROSS: At what point in time?
Q. Prior to July of '91.

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MR. OHLEMEYER: Thank you.
A. Well, all I had was what she told me. I didn't know this lady before.
Q. So your opinion, in July of '91, is only as good as the information that's available to you.
A. Information that was presented to me at the beginning, when she presented to my service, when Scott Walker asked me to see the patient; during the time that I talked to her husband; during the whatever weeks I took care of her and her family, that's the information I used to make this diagnosis.
Q. Well, I want to separate your diagnosis from your opinion about the cause of her death. I want to make sure you're not -- we're using -- when you say "make the diagnosis," do you mean the diagnosis of primary adenocarcinoma of the lung or do you mean the diagnosis or the opinion you've reached about the cause of her disease?
A. As far as I'm concerned, when I write this on a dictation like this, that's a legal record, and so my opinion and my diagnosis are essentially the same. There was nothing

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else to explain this diagnosis.
Q. Okay.
A. And I do the same thing with head traumas that are involved secondary to multiple vehicular accidents, end stage liver disease secondary to alcoholism, end stage renal disease secondary to whatever.
Q. Would you agree with me, Doctor, that in --
THE WITNESS: Excuse me, could I get a drink of water?
MR. OHLEMEYER: Sure.
MR. CROSS: Let's take a break.
(A recess was taken.)
MR. OHLEMEYER: Back on the record.
Q. Doctor, if you don't understand a question, will you let me know?
A. Yes.
Q. On June 21st, you note that the family would like an autopsy if possible. Do you recall having a conversation with Mrs. Wiley's family about an autopsy on or about June 21st?
A. Well, if it says that the family requests, given her family request, would like autopsy if possible, I must have had a conversation.

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We don't do autopsies without permission.
Q. Did you suggest to the family that they ought to consider an autopsy?
A. I cannot recall.
Q. Do you typically do that?
A. If a patient's death is difficult to explain to the family, if there's questions, whether they could have changed some behavior, done something, or possibly if there's a possibility of infection, such as tuberculosis, or some type of malignancy, that the family would need for their future care, oftentimes we will suggest it to them.
Q. Let me back up for a second. Your opinion that this was an adenocarcinoma primary to the lung, I may have asked you, is that an opinion that is recorded anywhere in these medical records prior to your death summary?
A. Your question is -- what's your question again?
Q. My question is: Where besides your death summary do you describe this tumor as a primary adenocarcinoma of the lung or where does any other doctor describe this tumor as a primary adenocarcinoma of the lung?

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A. Well, from Dr. Baldwin's note, the pathology report, I think you have that, it states that this fine needle aspiration, according to both him and Dr. Sandquist, was adenocarcinoma of the lung.
Q. Well, adenocarcinoma found in the lung doesn't necessarily tell you that it began in the lung, does it?
A. Adenocarcinoma that is found in the lung does not always begin in the lung if it's a metastatic lesion.
Q. And in fact, Doctor, isn't the lung one -- isn't the lung the most common place for metastatic lesions to occur?
A. Oftentimes breast cancer, some other types of tumors may go to the lung. But the problem is, is that her presentation was such, especially her x-ray -- usually with metastatic lesions to the lung you will have both lungs involved. It would be awful unusual with this large of tumor mass. I mean, that would not be our working diagnosis.
Q. Doctor, I don't mean to interrupt you --
MR. CROSS: Then don't. Let her

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finish her answer.
Q. My question is specific. Finish your answer, Doctor, but let me tell you this, if you would listen to my questions --
A. I am listening.
Q. -- I think we'd get along better and move a little faster.
My question doesn't deal with Mrs. Wiley, my question deals with general medical principles, and my question to you, Aren't metastatic neoplasms to the lung the most common type of tumor found in the lung?
A. I can't tell you that for sure. I'm telling -- her presentation, or whoever, okay, the presentation of a lung cancer, whether it's been Mrs. Wiley or not, with a large mass, that was an endobronchial lesion, that was not consistent with a metastatic lesion.
Q. Doctor, my question to you is, yes or no, are metastatic neoplasms to the lung the most common tumor found in the lung?
MR. CROSS: Asked and answered.
Q. Yes, no, or I don't know?
MR. CROSS: Objection.

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A. That may be true. It's hard to say.
Q. Are carcinomas metastatic to the lung the most common subgroup of malignancies?
A. Carcinomas --
Q. Metastatic to the lung the most common subgroup of malignancies.
A. I can't tell you that for sure. I'm not an oncologist.
Q. Can virtually any malignancy spread to the lung?
A. Can virtually any malignancy spread to the lung. Well, being not an oncologist and the fact that there are probably occasionally some extremely weird type of presentations, when I'm looking at chest x-rays and lung cancers, there are certain cancers that are more likely to spread to a lung than others.
Q. Are the most common malignancies that spread to the lung malignancies that arise in the breast, colon, stomach, pancreas, and kidney?
A. Breast, colon, stomach, pancreas, and kidney. It's possible. Again, I'm not an oncologist, but they can spread to the lung, yes.

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Q. Are adenocarcinomas the most common type of extrathoracic tumor that metastasizes to the lung?
A. Are adenocarcinomas the most --
Q. Most common type of extrathoracic tumors that metastasize to the lung?
A. Since not being an oncologist, it's possible.
Q. Is it a challenge to you, as a physician, in treating an individual to determine whether a tumor that you observe in the lung is a primary or a metastatic tumor?
A. Yes.
Q. Can atypical presentations of metastatic disease to the lung cause confusion with primary lung cancer?
A. Atypical presentations, what is your term? Define that.
Q. Well, what does it mean to you? An atypical presentation?
A. I don't know, I've not used that term before. An atypical presentation. If you could define it for me, I could answer it.
Q. Is it more or less difficult to distinguish a primary from a metastatic cancer in the lung when it's found in an endobronchial location?

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A. Well, since I have not seen any metastatic lesions arise from the bronchus, I can't answer your question. Metastatic lesions are usually peripheral, they're usually bilateral, they are not a large tumor mass that circumscribed in one area of the lung, that if I was looking at -- if I had blind x-rays put in front of me, I could say that this is a primary lung versus metastatic. Does that answer your question?
Q. Well, Doctor, you can only answer it the best way you can answer it. All I want you to do is answer the questions. If you can't answer them, you tell me you can't answer them.
A. Yes.
Q. In your opinion, Doctor, or in your experience -- well, tell me whether you agree or disagree with this statement: Endobronchial metastases can be confused with centrally placed primary lung carcinomas.
A. Endobronchial metastases can be confused --

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Q. With centrally placed primary lung carcinomas.
A. Again, you would have to, in my opinion, you would have to take the complete presentation. You would not just take the lung out and say that this is an endobronchial lesion secondary to metastasis. If the presentation is such that this is a primary lung, you diagnose it as a primary lung. If there's no other source for the adenocarcinoma, then that is not metastatic.
Q. Well, how do you determine whether there may be another source for the adenocarcinoma?
A. You do CT scans. You complete the evaluation of the entire patient.
Q. Is adenocarcinoma a type of cancer that can arise in the largest number of organs in the body compared to small cell or squamous cell carcinoma?
A. Well, small cell and squamous do arise from other organs but, again, it's the presentation. It also has to do with the pathology report. Adenocarcinomas from other sites such as breast, or pancreas,

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would look different to a pathologist, I would suspect, and he would have said this appears to be from some other lesion besides the lung.
Q. Let me stop you right there, Doctor. Are you telling us that a pathologist can look at a tumor and determine from where in the body it arose? Well, let me make it even a clearer question.
Are you telling us that a pathologist can look at an adenocarcinoma and determine where that adenocarcinoma originated?
A. There are characteristics that are more likely another source than the lung.
Q. What are those characteristics?
A. I'm not a pathologist.
Q. So you don't profess any background, education, or experience in determining whether you can look at an adenocarcinoma under the microscope and tell us from what part of the body it originated.
A. From when I was in medical school and from my experience as a clinical physician, I can tell you that a pathologist can look at a slide and say these have the tendency or

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characteristics that are not -- that would lend you to diagnose that this cancer came from someplace else.
Q. Tell me where in Exhibit 51, that you have in front of you, the pathologist gives us any information about where that adenocarcinoma originated.
A. It doesn't. Well, it does right here: "Fine needle aspiration, lung, right upper lobe: adenocarcinoma."
Q. So what that tells us is that adenocarcinoma was found in the lung.
A. Yes.
Q. It doesn't tell us that it started in the lung.
A. The fact that they did not tell you that there was probably some type of characteristic that it would have started someplace else, if I read this, I would say this is primary lung.
Q. Well, Doctor, are you telling us that all you need to know is that adenocarcinoma is found in the lung to reach a reasonably certain conclusion that it's primary to the lung?

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A. That's not what I said.
Q. Then tell me what is it about that report that leads you to believe that is a primary adenocarcinoma of the lung besides the fact that the adenocarcinoma was found in the lung.
MR. CROSS: Objection, asked and answered.
A. Your question is, what about this tells me that this was primarily lung.
Q. Yes. "This" being the exhibit that we referred to.
A. Yes.
Q. Tell me where and how from that information you can determine that that is a primary adenocarcinoma of the lung as opposed to a primary adenocarcinoma, or an adenocarcinoma that is found in the lung?
A. Well, because they had a -- when a pathologist -- when a pathologist does a fine needle aspiration of a large mass, okay -- and again, not being a pathologist, I'm telling you from my opinion and my clinical experience of 20 years -- when a pathologist looks at a fine needle

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aspiration, then it has a large mass in the lung, there is a small mass in the chest wall, okay, they look at the same -- there's a fine needle aspiration here, of the lung, they remove the mass from the chest wall.
This was -- this pathology report is consistent with primary lung cancer. If I would read this, if I -- if I had another person's chart and I went through the whole chart and I looked at this piece of paper and that was with another chart, I would still say that this is a primary lung from what these people are saying.
Q. Doctor, my question -- you don't have the chart, Doctor, all you have in front of you --
A. Yes, I do. I have the chart in front of -- here.
Q. My question is if all you had in front of you was that pathology report, the fact that a pathologist found adenocarcinoma in the lung doesn't in and of itself tell you where that cancer came from, does it?
A. The fact that they did not state that this most likely is some other source besides the

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lung, this is consistent to me as primary lung cancer.
Q. Doctor, my question isn't is it consistent with. My question is, could we put that on a table and you walk into a room and pick it up and not have anything else on the table and look at that piece of paper and say this is a primary adenocarcinoma of the lung?
A. Yes.
Q. Why?
A. Because it does not state that the characteristics of the cells are anything other than primary lung cancer.
Q. And it's your belief that a pathologist can look at an adenocarcinoma under the microscope and determine from where that tumor originated in the body.
A. There would be characteristics that they would lend towards one organ or another, or primary lung.
Q. To the extent a pathologist in this case testifies to the contrary, do you agree or disagree with that opinion?
A. In this case. This patient, that's what you asked.

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Q. Let me give you a hypothetical. If a pathologist, someone who has background, training, who is board certified in pathology --
A. Yes.
Q. -- tells the jury in this case you can't look at a tumor under the microscope, you can't look at an adenocarcinoma under the microscope and determine from where in the body it started, is that an opinion with which you disagree?
A. There are certain characteristics of adenocarcinoma that would allow the pathologist to make an educated guess whether that was from another source or not.
Q. But are you telling us, with reasonable certainty, that you have the background, the education, the experience to look at the pathology or the pathology report in this case and tell the jury that?
MR. CROSS: Well, I'm going to object.
MR. OHLEMEYER: I'll withdraw the question.
Q. Doctor, have you done any research on

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endobronchial metastases?
A. Endobronchial metastases, no.
Q. Have you done any research on metastatic tumors to and from the lung?
A. Research?
Q. Yes.
A. Or reading?
Q. Either.
A. Research or reading? Reading I have. Research, no.
Q. What have you read?
A. Well, I don't have the books in front of me. It was several texts.
Q. Have you read that true primary bronchial adenocarcinomas are rare and often derived from bronchial glands?
A. Can I see the -- your paper?
Q. My question is, Doctor, have you read true primary bronchial adenocarcinomas are rare and often derived from bronchial glands?
A. True primary --
Q. True primary bronchial adenocarcinomas are rare and often derived from bronchial glands.
A. Bronchial glands. I can't tell you whether

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I've read that or not. That is, they come from adenocarcinoma. I mean, that's --
Q. Is it fair to say, Doctor, that most primary lung adenocarcinomas are peripheral?
A. Most primary lung adenocarcinomas are peripheral, yes.
Q. Why was an autopsy conducted in this case?
A. One thing, the patient's family requested it.
Q. Any other reason? What would the purpose of an autopsy be in this case?
A. Well, I think I've already answered. The fact that this family had questions, possibly as a cause of her death, perhaps they were concerned about whether they should have changed something earlier, you'll have to ask them what their ideas were.
Q. Did Mr. Wiley ever express any frustration to you about the quality of care his wife was receiving at Ball Memorial?
A. No.
Q. Never had a discussion with him about that?
A. No. In fact, if you look through the nurse's notes, there was a -- I can't find

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them exactly right here, but towards the end of her life he apparently came out of the room and specifically told the nurses that they were very special people and that he was crying and that he really appreciated their care.
Q. Dr. Turner, Mr. Wiley testified in this case that you associated his wife's cancer with her exposure to cigarette smoke on or about May 30th.
A. May 30th. That was the day after she came in.
Q. Do you recall telling him that if she had cancer that you thought it would be associated with her exposure to cigarette smoke?
A. I do not recall that.
Q. Do you recall him telling you -- you recall telling him that -- did you suggest to Mr. Wiley that an autopsy be conducted so that you could find out the real cause of his wife's death?
A. I do not recall that if it's not in my notes. I may have or have not.
Q. Did you ever tell Mr. Wiley that an autopsy

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should be performed to find the primary tumor from which his wife suffered?
A. If he stated that in his deposition, then, you know, I probably did.
Q. Well, do you believe or did you believe that an autopsy should be performed in order to find the primary tumor?
A. Given the fact that it was eight years ago or seven years ago now, did I believe that we did not have the source from what we had --
Q. My question to you, Dr. Turner, is did you believe an autopsy should be performed to find the primary site of the tumor?
A. I can't tell you that for sure. All I know is that an autopsy was performed.
Q. Do you think an autopsy was necessary to find the primary site of the tumor?
A. I think an autopsy was necessary to define how extensive the tumor was, yes.
Q. Do you think an autopsy was performed to find the primary?
A. Well, given the fact that, from the notes that I have here, and from my discharge summary, we felt that her primary lung was

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the source -- is that what you're asking?
Q. Let me rephrase the question. Did anyone ever tell you that an autopsy was performed to find the primary?
A. I can't tell you that for sure. It's been seven years.
Q. Did you ever tell anyone else to perform an autopsy to find the primary?
A. I can't tell you that. It's been seven years ago. I mean, what does the autopsy report -- I mean, there's a request for an autopsy. If Mr. Wiley requested an autopsy and if he states something then I'm sure he -- but I can't -- I've taken care of too many patients. I can't -- I don't want to lie to you.
Q. Do you think an autopsy -- did you think at the time of Mrs. Wiley's death an autopsy was necessary to find the primary?
A. I can't tell you that. All I know is from my notes and from the way the discharge summary was written and dictated, and the way I wrote the face sheet out, we had the primary source.
Q. All right. Then explain to me, Doctor, why

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in your death summary you state an autopsy was performed to find the primary.
A. Then obviously I thought this. Why didn't you bring that up in the first place? Where is this at?
Q. Last -- right there.
A. To find the primary. Okay. There it is. Not like I'm hiding something, it's written right there.
Q. So at the point -- as of July of 1991, there was some question in your mind as to where Mrs. Wiley's primary cancer might --
A. July 21?
Q. 1991.
A. See, the problem is -- the autopsy was performed when?
Q. Well, Doctor, my question to you is, as of July 1991 --
A. July 21st or when?
Q. As of July 21, 1991, was there any question in your mind as to where Mrs. Wiley's primary cancer originated?
A. Well --
Q. Or let me rephrase the question. Was there any question in your mind about the primary

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site of Mrs. Wiley's cancer?
A. Well, July 21st is when I dictated the discharge summary. The autopsy was performed when?
Q. Doctor, can you answer the question?
A. I'm trying to answer the question. The point is, this dictation was done after the autopsy was completed. Okay? So therefore, when I dictated the discharge summary I dictated, it says, "the patient died quietly on 6/24/91 with her family at her bedside. Autopsy was performed to find the primary." Therefore, I dictated this on the 21st of July. We already knew -- I mean, the autopsy was completed. This confirmed our initial diagnosis of primary lung carcinoma.
Q. Is it your testimony, Doctor, that you had the autopsy report prior to the time you dictated the death summary?
A. I don't know. When was the autopsy report?
Q. Mr. Cross has handed you --
MR. OHLEMEYER: Quite frankly, Mr. Cross, I don't think it's proper for you to hand the witness --
A. Well, you hand it to me then. How's that?

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MR. OHLEMEYER: -- hand the witness information while questions are pending, tell you the truth. But, be that as it may --
MR. CROSS: Well, then I don't think it's fair for you to ask the witness to rely from memory hundreds of documents.
MR. OHLEMEYER: I think the witness's memory is going to be -- certainly is a fair area of inquiry in this case and I prefer that you let me conduct my examination the way I want to conduct it.
MR. CROSS: Well, as long as you stay within the limits of the procedure.
Q. Doctor, the autopsy report is marked Exhibit 16. My question to you is at the time you dictated your death summary in July of 1991, did you have a copy of the autopsy report and, if so, show me in this death summary where you refer to it.
A. Does it say that I did?
Q. Well, I don't see it.
A. Well, then, obviously, I didn't. Or it's in the chart that -- I mean, the problem is with autopsies, the autopsy, we don't get

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reports. Does it say when it was finally dictated? I mean, I have autopsy reports a year after they're completed.
Q. So am I correct that even though the autopsy in this case was performed prior to July of '91, you may not have had and, in fact, there's no indication that you had a copy of the report prior to the time you dictated the death summary.
A. If it doesn't say, then I can't tell you. Again, autopsy reports, depends on who's dictating them, are they waiting for the micro reports to come back, that takes time. And therefore, I may not have the autopsy. Or I could have had the autopsy report at the time of my dictation. I can't tell you because if it's not dictated --
Q. All right.
A. Can I look at that?
Q. You can, but there's no question pending.
A. Okay.
Q. My question, my next question, Doctor, is at the time you dictated the death summary, how did you rule out primary carcinoma of the breast or primary carcinoma of the pancreas

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or primary carcinoma of the stomach or primary carcinoma of the colon metastatic to the lung?
A. Number one, her breast examination was negative. She had had previous mammograms in the fall of '90, I believe, at Marion General. And I had examined her breast, Dr. Songer had examined her breast, Dr. Sprunger had examined her breast, there was no source there.
Number two, the pancreas, the CT report -- and I need to look that up, but there was no evidence of a mass -- let's see here. CT of the abdomen and pelvis: The liver was within normal limits, the pancreas was not enlarged, the kidneys and spleen were normal. So the other question?
Q. What are you reading from?
A. The CT report on 6/3/91. And there was no evidence of thickening -- I mean, they would have stated, if there was some suspicion of something in the stomach, they would have stated something at the time.
And the other thing is, she did not have any symptoms consistent with that. I

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mean -- I mean, her major problem, her presenting chest x-ray was a hilar mass with volume loss in the right lung. Usually patients with pancreatic cancer present with weight loss, nausea/vomiting, and abdominal pain. Vague abdominal pain.

Q. Did Mrs. Wiley have a history of vague abdominal pain?

A. Well, what was my H&P? She had no difficulty swallowing, she did have a persistent cough, she had hoarseness, she had hemoptysis or streaking of blood in her sputum, she denied GI upset, denied chest discomfort with the exception of some heaviness with severe coughing.

Q. Let me put it to you this way, Doctor.

A. Yes.

Q. If it's not in this admission note, you don't know whether she had a history of abdominal discomfort or she had prior GI workups or had sigmoidoscopies or had --

A. She had no diarrhea, no constipation, the patient denied any bowel changes, no GI distress. To me that says she did not have any nausea/vomiting -- not nausea/vomiting,

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she did not have abdominal pain, she did not have symptoms saying that her primary was in the belly.

Q. Do you know if Mrs. Wiley ever had any GI workups prior to the time she was admitted to Ball Memorial?

A. If they're not in this history, not in my H&P, and I don't recall them, no.

Q. So it's possible Mrs. Wiley had symptoms that either weren't reported to you or weren't included in the information available to you at the time you took the history.

A. It's possible, but usually people are pretty forthcoming, they're scared to death. And the other thing is, with the CT scan, if that was a problem, thickening of the stomach wall, a mass in the stomach, I would have suspected they would have picked that up on the CT scan.

Q. What do you mean, people are forthcoming?

A. That means, if you're facing death, and you're concerned that you're dying, people tell me things that they probably didn't even tell their families.

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Q. You would expect somebody in Mrs. Wiley's position, especially in light of her background and experience as a nurse, to provide you with as much detail and accurate information as she could about her history.

A. Yes.

Q. You would expect that she would do that with all of her doctors, wouldn't you?

A. If they asked the right questions.

Q. Well, wouldn't you expect the doctors at Ball Memorial to ask the right questions?

A. If they were taking a complete history and they were doing a thorough examination, yes.

Q. So is it fair to say, Doctor, that the only information available to you to rule out a primary from a distant site at the time you dictated the death summary is the information contained in the medical records you've previously produced to us.

A. I cannot tell you for sure, yes or no, whether I had the autopsy report. If I did not have the autopsy report, it would have been related to the pathology report and what I ascertained from her tests and what we found at the time of her hospitalization.

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Q. Now, at the time she died, Mrs. Wiley had been treated for breast cancer; isn't that right?

A. Where is that at?

Q. Well, did you ever -- you've talked about this case with Dr. Songer, haven't you?

A. Not very much.

Q. That's your testimony?

A. We've discussed the case off and on.

Q. You know that --

A. But not extensively, no.

Q. You know that Dr. Songer did not treat Mrs. Wiley with aggressive chemotherapy during her hospitalization; isn't that right?

A. Did I know that Dr. Songer did not treat Mrs. Wiley with aggressive chemotherapy.

Q. Let me rephrase the question. What treatment did Dr. Songer provide to Mrs. Wiley during her hospitalization?

A. Well, the treatment that he provided, we provided, was the fact that we started -- we tried radiation, and I believe he tried -- let's see here. I think he was attempting to see -- let's see here. He started her on

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tamoxifen on the 10th of June.
Q. What is tamoxifen?
A. Tamoxifen is an antihormonal therapy.
Q. What is it used to treat?
A. It can be used to treat breast cancer.
Q. And is that why it was prescribed in this case, because of the suspicion that Mrs. Wiley might have breast cancer?
A. As you note in his chart, on the 10th of June Dr. Songer states, "Although a breast primary seems unlikely, I see no contraindication to treating patient empirically with antihormonal therapy."
Q. Why don't you read the last --
A. "Based on high CEA and CA15-3."
Q. What does a high CEA and CA15-3 indicate to you?
A. Well, I'm not an oncologist. These tests --
Q. Well, it indicates to an oncologist --
MR. CROSS: Let her finish the answer, please.
Q. Go ahead, Doctor.
A. They can be used as tumor markers.
Q. For what type of tumor?
A. Well, there's a number of them and there's a

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chart in here. CEA is often elevated in a number of tumors, can -- can be related to GI, related to others. CA15-3 --
Q. I don't want to interrupt you but it's most often associated with primary breast cancer; isn't it?
A. CA15-3? Now it's not because it's not used anymore. That's my understanding.
Q. Doctor, in 1991, the use of tamoxifen to treat a woman with an elevated level of CA15-3, I mean, why would you -- why was he treating her with tamoxifen?
A. Because that's all we had left to offer her.
Q. And in June of 1991, what did an elevated level of CA15-3 suggest to you as a clinician?
A. Well, I'm not the oncologist.
Q. What does it suggest to an oncologist then?
A. That may be in the differential.
Q. The differential being a primary breast.
A. Yes, but it doesn't go along with her clinical presentation.
Q. Well, be that as it may, Dr. Turner, all Dr. Songer did in terms of treatment is treat Mrs. Wiley with tamoxifen; right?

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A. He was trying to help her in any way he could.
Q. He did not treat her the way an oncologist typically treats someone with adenocarcinoma of the lung.
A. Well, since this was the 10th and we didn't know she had adenocarcinoma until the 14th, this was started four days before. From the type of presentation and the level, where we were on the 10th of June, he was just trying to do anything possible for this poor lady.
Q. But he never treated her --
A. And the problem is, I mean, tamoxifen, he was trying to do anything that he could without causing her harm.
Q. But did Dr. Songer ever treat Mrs. Wiley for adenocarcinoma of the lung?
A. No.
Q. And what he did treat her --
A. Yes, he did in a way, because of the radiation.
Q. Well, you're smiling, you scored a point.
A. No. Don't talk like that.
Q. I apologize.
Dr. Turner, what he did do is treat her

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with a drug that is and was typically used to treat women with primary carcinoma of the breast.
A. Yes. But that doesn't mean -- oftentimes we have a patient that will present and we don't have the diagnosis, the patient is deteriorating, and we do what we can to do -- the best we can with the information that we have.
Q. And the information that you had was that Mrs. Wiley had an elevated marker that was associated with primary carcinoma of the breast.
A. Yes.
Q. Okay. Now, let me make sure we're not confused about something. The radiation treatment had nothing to do with Mrs. Wiley's lung, did it?
A. Yes, it had everything to do -- well, it had to do -- we were radiating.
Q. Let me rephrase the question. There was no radiation directed to the lung.
A. No.
Q. It was directed to the metastasized -- or to the tumors that were observed in other parts

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of her body.
A. It was directed, if I'm not mistaken here -- I'll have to look at Dr. Dickerson's notes -- but it was directed to the lumbar spine because she was having so much pain.
Q. Do you know whether there were --
A. She had radiation palliative. Radiation therapy to L-1 through 3.
Q. That's not the lung; right?
A. No. And mid-right femur.
Q. That's not the lung; right?
A. Right. Because the tumor was eating away her bone and that's where she was having the most pain.
Q. So there was no radiation directed to her lung; right?
A. Not at that point, no.
Q. There was no chemotherapy directed to -- prescribed because of a diagnosis of adenocarcinoma.
A. We ran out of time.
Q. And the only treatment that was prescribed is a treatment that is consistent with or typical of the way you treat a woman with primary carcinoma of the breast.

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A. No. That's not true. We treated -- Dr. Songer started tamoxifen because of the elevated tumor markers.
Q. Is tamoxifen used to treat people with lung cancer?
A. No.
Q. Okay. Doctor --
A. But let me finish my statement. What you said was the treatment -- did we treat the patient with -- for her lung cancer. We did not at that point. We did treat with radiation. And you notice that what we're doing, here's this poor lady, she has elevated markers, even though her breast examination is negative, even though she had a negative mammogram, we felt that's all we could offer her. The radiation was to be treating the femur as well as L-1 through 3 because the bones were being eaten away. So we were essentially trying to treat whatever -- whatever cancer was present.
Q. Doctor, after Mrs. Wiley died, how did you get involved in her claim, her husband's claim for compensation?
A. Well, I received a letter -- I don't have --

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if it's here, I'd have to find it -- requesting that I give my opinion as to the cause of her death.
Q. And in your opinion, her death was related to her employment at the VA.
A. In my opinion, her death was related to environmental tobacco smoke.
Q. Well, let's back up. From whom did you receive the letter?
A. I must have received it from the attorneys. I don't know for sure. I don't know where I got it from. Does it say where I received it from?
Q. Doctor, I don't -- if you have a letter, if you have a letter, I'd be happy to talk with you about it, but --
A. Well, I don't know either.
Q. So you recall receiving a letter from somebody. Is that right?
A. I'm stating that I was contacted. And if it was by letter, I'd have to find it in these papers.
Q. Which, if it was attorneys, which attorneys?
A. Well, if I could find the letter I would tell you that.

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MR. OHLEMEYER: Let's mark this as the next exhibit.
(Deposition Exhibit(s) 18 marked for identification.)
Q. Doctor, let me hand you what we've marked as Exhibit 18, and ask you, it's a handwritten note that has 1716 West 10th, Jonesboro, Indiana 46938, Philip, and then it says "pursue lawsuit for VA" underlined, "for VA," three times, "help any way can," and then it says, what? What's that last word down there?
A. I can't read it.
Q. Is it your writing?
A. No, it's not.
Q. Whose writing is it? Do you recognize it?
A. No. It's probably one of the secretaries.
Q. So is this --
A. I'm not sure it's the secretaries but it's not my writing.
Q. This is a document that you have produced to us. Can you explain it for us?
A. All I know is, most likely it's related to the fact that I was requested to look at the evidence and see if there was enough

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evidence or if the evidence was adequate to pursue legal actions.
Q. And does it suggest to you who made that request of you?
A. No. I mean, whoever wrote this, whoever wrote this, help any way can. I can't read the last writing. The last word.
Q. Is this something you could show your secretary maybe on the break and see if it's her handwriting?
A. We could find out and see if it's Sylvia's or someone else's. I'm not even sure the date this was written.
Q. Did there come a time, Dr. Turner, where you suggested to either Mr. Wiley or his attorneys that they should file a lawsuit against the tobacco companies?
A. I believe when she died, after she died, the family was crying and very, very upset and we had -- my concern was before, because of her exposure, that they should consider this because I felt that her death was directly attributed to secondhand smoke.
Q. And this was at or near the time she died.
A. Yes.

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Q. So did you suggest to them at that time to hire lawyers?
A. I don't believe I did. If I did, I did.
Q. Did you ever help them hire lawyers --
A. No.
Q. -- or assist them in any way?
A. No. Are you kidding?
MR. OHLEMEYER: Let me mark as Exhibit 19 next in order.
(Deposition Exhibit(s) 19 marked for identification.)
Q. Doctor, I've handed you what we've marked as Exhibit 19. It says "Wiley, Mildred, May 3, 1993." On the bottom it says "NCT:dh." This is your dictation.
A. Yes.
Q. First sentence, "On May 3 I discussed this case with J.L. Repace." By "case," do you mean medical case or legal case?
A. Probably both.
Q. Do you know whether a lawsuit had been filed at this point in time?
A. No. I don't believe it had. I don't know for sure.
Q. Who is J.L. Repace and why did you call J.L. Repace?

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A. I was contacted to see if there was sufficient evidence or sufficient cause and was I sure of the diagnosis. And I was sure of the diagnosis and, after reviewing the chart, because, obviously, it had been two years, and I had, truthfully, I had not reviewed the literature, any of the cases, and they asked me to look at that and to see if I could get other opinions to see what their thoughts were regarding this case.
Q. Who is they?
A. The attorneys.
Q. Who?
A. The attorneys. Young.
Q. So it's your testimony that prior to May 3, 1993, you had talked with Attorneys Young --
A. Yes.
Q. -- and others about, about what? About Mrs. Wiley?
A. First of all, apparently what happened was they had been contacted by her husband -- and that happens to me sometimes. I will be called by an attorney, a group of attorneys to look at a case, to see what my thoughts

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were, was it malpractice, was this -- was there liability involved, and that's what I was doing.
Q. You certainly didn't think there was any malpractice involved.
A. On our part, no.
Q. So who is Repace? Why did you call him?
A. Repace was an individual -- I'd have to look at the literature, but he has a -- he has done work for the Environmental Protection Agency, my understanding -- I have to look at the literature again to review this -- but he has done work for the Environmental Protection Agency and his name was on some literature that I had read regarding environmental tobacco smoke.
Q. And it appears that he told you at least three things. One thing he told you was that this was a good case. Meaning a good legal case; right?
A. That this was a case for environmental tobacco smoke as a causative etiology of her cancer.
Q. Well, at this point in time, the reason you're interested in that has to do with

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legal proceedings, not medical proceedings.
A. Not really. My purpose was to see if her case was the -- if her cause of death was related to environmental tobacco smoke. I mean, happens --
Q. In connection with legal proceedings.
A. And -- yes.
Q. So the next thing you did, or the next thing he told you was you should call a Dr. Richard Daynard at a law school; right?
A. Yes.
Q. Do you know who Dr. Daynard is?
A. Yes.
Q. Who is he?
A. He's an attorney that, I believe he resides at the Northeastern School of Law in Boston and he helps individuals who feel that -- and he does -- I'm not sure all the things he does, but I have read some of his literature. And I don't know if it was before or after this, I have attended lectures by him.
Q. On?
A. On tobacco.
Q. Lawsuits against tobacco companies?

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A. On tobacco.
Q. Well --
A. He appears at symposiums on educating physicians as well as others about tobacco.
Q. Well, how much continuing medical education do you typically obtain from lawyers?
A. Well, it's interesting because that is probably one of the only attorneys that I have heard. Maybe there's a couple more, but I can't remember their names, that I have went to national conferences and heard speak.
Q. And do you know what Dr., or Attorney Daynard believes the role of these types of lawsuits plays in the broader public health issues related to smoking and health?
A. You'd have to ask him directly to see what his opinion is.
Q. What's your understanding of his opinion?
A. All I know is, is that he publishes. And I don't really know how long Tobacco On Trial has been out, I have no idea, but he publishes information regarding the tobacco industry and their liabilities and what they do to the public.

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Q. In lawsuits. Their liabilities in lawsuits. Right?
A. I don't know about lawsuits. Their liability in the health problems brought on by their products.
Q. Well, you know, if -- tell me where, what sources of information you go to for medical information about the health effects of smoking.
A. Well, I can go get them if you like. I have --
Q. Just give me a general --
A. I have a number. I think it's in most of the textbooks.
Q. Medical textbooks?
A. Yes.
Q. Medical journals?
A. Yes.
Q. Tobacco On Trial?
A. Yes. Well, I don't know. A lot -- part of that -- a lot of it has to do with public access to smoke-free buildings, things like that. Also signs and -- I mean, that covers a lot of gamut. I mean, a lot of area that that literature covers, Tobacco On Trial.

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Q. And you just take Dr. Daynard's -- Attorney Daynard's word for it on the factual issues described in his publication; right?
A. Do I take his word for it?
Q. I mean, how do you know what he's telling you is accurate?
A. Well, just like any other literature, I would expect if he -- if someone -- if you were writing a paper and you were going to be published nationally, or internationally, I would hope that you would be truthful.
Q. Well, in a medical journal, they do more than hope, don't they? They peer review.
A. Yes.
Q. Do you know if Dr. Daynard's or Attorney Daynard's Tobacco On Trial is peer reviewed?
A. I do not know.
Q. Do you know what effort he makes to be truthful or be accurate or provide you with complete information?
A. Well, a number of articles that I have read from him are also similar to articles about the same subjects by other authors, so I can't imagine -- I mean, if you read from Daynard and you read the same thing from

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five or six other sources, including the medical literature, I would think that would be truthful and that would be --
Q. So if you repeat it enough, it's the truth.
A. No, that's not true. I mean, look at you guys.
Q. Let me ask you the next question: Dr. Repace told you something else, didn't he? Told you you could quantify Mrs. Wiley's exposure?
A. Said he would be able to quantify hopefully the exposure Mrs. Wiley had to secondhand smoke.
Q. And he couldn't, could he?
A. I don't know.
Q. He didn't, did he?
A. No, I don't know.
Q. Well, what did you mean, you don't know? Did you ever ask him did you?
A. I haven't talked to the man for I don't know how long.
Q. Do you know if -- did you ever recommend to the attorneys or anyone else that some effort be made to quantify her exposure to secondhand smoke?

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A. I may have.
Q. Well, who? Who did you tell?
A. I may have talked to the attorneys.
Q. Did they ever tell you what happened? Aren't you curious?
A. No. What I did tell them is what I had from the history, that she had been heavily exposed to secondhand smoke, that she had worked there a number of years.
Q. Well, Doctor, wouldn't it be important to determine Mrs. Wiley's exposure to secondhand smoke in determining whether or if her exposure was the cause of her disease?
A. Would it be determined --
Q. Would it be important to determine --
A. To determine the quantity.
Q. -- the quantity of her exposure, the level of her exposure if you wanted to determine whether or if that exposure played a role in causing her disease?
A. Well, from her history, she stated -- and I think when I talked to her husband, and from my dictation on the death summary, that her exposure was quite heavy. I mean, she had

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been exposed to secondhand smoke on the VA ward and --
Q. Well, I don't want to interrupt you but your history says she had been exposed to secondhand smoke for approximately 12 years in VA.
A. 12 years, yes.
Q. Did Dr. Repace tell you that it would be important or helpful to try to quantify that exposure in order to determine whether or if the exposure played a role in causing her disease?
A. I think it would be helpful from a legal point of view. The other thing that you must look at is one of my other dictations is the fact that after additional --
Q. Doctor, we'll get to that.
MR. CROSS: Let her finish her answer.
MR. OHLEMEYER: Well, she's answered the question. Now she's --
A. What you're doing is you're picking pieces from other things instead of looking at the big picture.
Q. Doctor --

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A. I know that's your prerogative.
Q. We're going a step at a time and, quite honestly, I understand you're trying to be helpful but if we go a step at a time we'll get there a lot faster.
And my question was, Is did Dr. Repace tell you that it would be helpful or important to try to quantify that exposure in order to determine whether it played any role in causing her disease?
A. Well, I'll tell you, all that's written down here is what I can tell you what he told me. He did state that he would be able to quantify hopefully the exposure that Mrs. Wiley had to secondhand smoke. Whether he did or not, I cannot tell you.
Q. What would the purpose of such a quantification be?
A. To see how much she was exposed to.
Q. Is there a level of exposure below which you wouldn't consider it to have played a role in the cause of her disease?
A. My understanding, according to the federal agencies that I've read and some of the surgeons general, there's no safe exposure

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to secondhand smoke.
Q. So if Mrs. Wiley was exposed to secondhand smoke on one day of her employment at VA, would you still believe with reasonable certainty that exposure caused her lung cancer?
A. Most likely not.
Q. Some point between one day and 12 years I take it you believe that the exposure did cause or contribute to causing the disease. What I want to know is where. Where do you draw that line?
A. I don't know. It has to do with the person. An alcoholic, if he drinks four beers a day, would that cause his liver cirrhosis? I can't tell you that. If somebody else drank six beers a day, they had or had not, it depends on their biochemical makeup. It depends on them.
Q. Well, do you think that if you could quantify her exposure, it could be compared to other exposures that had been established or demonstrated to produce a cause and effect relationship? I mean, is that one of the reasons why you'd want to quantify the

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exposure?
A. If they were able to quantify the exposure, that would -- I guess that would help. What he said is that would help with if there was a lawsuit or whatever.
Q. Would another way of comparing or considering the issue be to look at groups of people who had been studied in epidemiological studies to see what level of exposure they had, what the incidence of disease was, and then compare that to Mrs. Wiley?
A. I don't know if you can say that or not. I'm not an epidemiologist.
Q. Well, let's put it this way: If I had a group of nonsmoking women who I studied, and I knew that they had not been exposed to environmental tobacco smoke as children or outside the workplace, and I knew how long they were exposed in the workplace, and I knew how frequently lung cancer occurred in that group of women, that would provide me some information I could use to compare and contrast to other women to see whether they were or were not being exposed to something

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at a level that was associated with an increased incidence of disease; right?
A. Yes.
Q. That would be one way of trying to quantify Mrs. Wiley's situation, wouldn't it? Comparing her to a group of people who had been studied in other situations?
A. If the exposure was the same, it's possible. The thing is that, again, it has to do with biochemical makeup as well.
Q. Well, another way to do it would be to quantify the exposure in her actual workplace.
A. Yes.
Q. Another way to do it, I guess, would be to conduct some sort of analysis of Mrs. Wiley's body to determine whether or if she had been exposed to cigarette smoke.
A. Analysis of her body. In what way?
Q. Well, is there a way to test somebody -- let's back up.
If I came to you with an occupational history of exposure to asbestos, and I died, and you were suspicious of my history, you didn't believe me, you could conduct an

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analysis of my lung tissue --
A. Yes.
Q. -- to determine how much asbestos was there.
A. Yes.
Q. And you could compare it to other researchers' work that says in people who work for this many years around this much asbestos you find this much; right?
Can you do something like that with somebody who claims to have been exposed to cigarette smoke?
A. You can look at the most likely diagnosis of cancer, which is what we did. And you're asking -- what other type of chemical analysis are you looking at? Well.
Q. That's my question. Is there anything else you can do besides diagnose cancer? Is there any sort of biomarker or pathological finding that you can look for in somebody like Mrs. Wiley and say, okay, without knowing anything more about his or her history, this suggests to me this person had a prior exposure to tobacco smoke.
A. I believe there are some cellular markers now available or was then, I don't know,

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that would help you define whether that the thousands of chemicals that come off of cigarette smoke, side-stream smoke, some of those chemicals are carcinogenic. In fact, there's over 50 out of one cigarette. That there may be -- there was, I believe, or there is some markers that can be completed.

Q. We don't have any of that in this case, though; right?

A. I don't know if we do or not.

Q. Well, have you looked?

A. We don't -- I have not looked. I'm not -- I'm only -- the only opinion I have is from here, plus my clinical opinion. I am not a lawyer.

Q. Now, did Dr. Repace tell you whether it would be very important to look at radon exposure as well from the home?

A. Well, there's an increased risk of cancer, especially in cigarette smokers, if they have radon exposure.

Q. Well, let's back up. Does the EPA classify radon as a group A carcinogen?

A. Yes.

Q. A known human carcinogen?

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A. Yes. As they do other things. Including ETS, including asbestos.

Q. Including other substances that we encounter? There are things in the air we breathe, in the water we drink; right? Some of the foods we eat.

A. There are six. Vinyl chloride, I believe. I'd have to look at the list. Asbestos, radon, vinyl chloride, I believe benzene.

Q. Is there a safe level of radon exposure under which there is no increased risk of developing lung cancer?

A. It depends on where they live, whether they live in the basement, what kind of radon is occurring from the soil. Is there a safe exposure? I mean, I believe that a -- I'm not a physicist, but I believe that there is radon and some areas have higher radon loads than others.

Q. Doctor, my question is --

A. Is there a safe exposure.

Q. -- is there a safe level of exposure to radon.

A. I can't tell you for certain. I believe that under a certain level there is less

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likely chance of lung cancer. I mean, I would not like to be exposed to any of it. If that's what your question is.

Q. And the EPA believes and has written that any exposure to radon can increase your risk for developing lung cancer and, in fact, may cause lung cancer in such an individual. Is that right?

A. The EPA has written that it does increase your risk of lung cancer, especially if you're a cigarette smoker.

Q. Well, Doctor, is radon the second leading cause of lung cancer in this country?

A. Second leading cause, I believe it is. I'd have to look at my notes.

Q. Does radon cause thousands of deaths each year?

A. No, I don't think so. I would have to look at my notes again.

Q. Notes of what?

A. I've done research. You told me to be prepared. I'm trying to be prepared.

Q. Well, you're referring to some notes. When did you do this research?

A. I've been doing this research for probably,

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well, 16 years.

Q. Well, can you tell me whether or if the EPA believes that radon causes thousands of deaths each year in this country?

A. I can't tell you specifically how many deaths are due to radon. But it's much, much, much, much less than environmental tobacco smoke.

Q. Pardon me?

A. I said it's much less than environmental tobacco smoke.

Q. Your testimony, Doctor, is that the EPA attributes fewer lung cancer cases each year to radon exposure --

A. You said deaths.

Q. Well, let's back up then. Is it your testimony that the EPA attributes residential radon exposure to fewer cases of lung cancer each year than exposure to environmental tobacco smoke?

A. I can't tell you that answer.

Q. Do you know how many lung cancer deaths per year the EPA attributes to ETS?

A. About -- it's below -- I believe less than 3,000.

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Q. So I want to make sure we're clear, Doctor. Your testimony is that the EPA attributes fewer than 3,000 lung cancer deaths a year to exposure to residential radon.
A. Yes.
Q. Do you know whether radon is found throughout Indiana?
A. No, I do not.
Q. Do you know whether the EPA has ever done any study of Indiana, specifically Indiana counties to determine the average amount of indoor radon that might be found in a home in Indiana?
A. I can't tell you that.
Q. Do you know -- well, as of May 1993 what did you know about Mrs. Wiley's exposure to radon?
A. Well, since that note stated that it would be important to know that, obviously May 3rd of '93 I had no awareness of whether she was exposed to radon or not.
Q. So Doctor, did Dr. Repace tell you that radon exposure was believed to be a cause of lung cancer in nonsmokers?
A. It can occur. Did Dr. Repace tell me

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that --
Q. Did you know that before May of 1993?
A. I can't tell you that. I mean, we all know that radon can cause lung cancer. Especially in cigarette smokers.
Q. But Mrs. Wiley wasn't a cigarette smoker.
A. Right.
Q. Did you know in May 1993 that radon exposure, residential radon exposure was a cause of lung cancer in nonsmokers?
A. Probably, yes.
Q. And did you know that in July of '91 when you dictated your death summary in this case?
A. Probably, yes.
Q. And what effort did you make prior to May of 1993 to determine whether or if Mrs. Wiley had a residential exposure to radon?
A. I didn't make any effort. Because that is so low on the probabilities that I didn't pursue that.
Q. Low on the probabilities, explain that.
A. That that was the primary cause of her lung cancer.
Q. Why is it low on the probabilities?

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A. Primarily because, first of all, it's -- very, very few people, nonsmokers, die of lung cancer secondary to radon. Second of all, with her presentation of an endobronchial lesion, I mean, it's just not very frequently seen. I mean, if you look at statistics, doesn't -- you know.
Q. Well, prior to July of 1991, how often had you seen an endobronchial lesion in an nonsmoker?
A. I had not.
Q. Now, you talked with Dr. -- with Attorney Daynard about the fact that we are short on funds.
A. Yes.
Q. Explain that sentence to me.
A. Where is that at?
Q. Who is we?
A. Well, we are short on funds, most law firms, if they're going to take such a case, would take it on a contingency fee.
I would suspect that it was whoever was asking me if my opinion -- they were asking me my opinion whether this would be a case or not, and I would suspect I was probably

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talking in generalities.
Q. Well, who is we generally as you use the word?
A. I would suspect, given -- and truthfully, given the tobacco money that you guys have, billions of dollars that you make, and the way that lawsuits are done, that an individual -- and again, I had not talked to Mr. Wiley since the day she died, that I'm aware of; if I did I can't remember -- that if, indeed, there was a lawsuit that he was talking about that it was him.
Q. Doctor, my question to you is, in this sentence, one, two, three, four, five paragraphs down, who are you referring to as we?
A. That's what I just answered to you. It's probably Mr. Wiley.
Q. And Attorney Daynard recommended you talk to a Dr. David Burns in San Diego. Is that right?
A. If that's what it says, that's what I said.
Q. And what did you know about Dr. Burns at that time?
A. Nothing.

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Q. Did Dr. Daynard tell you that he typically testifies in lawsuits like this?
A. Dr. David Burns in San Diego is one of the chief scientific authors of the EPA report and has done extensive research in this area. That's what it says. It says that he is a chief scientific author of EPA. Whether he -- whether he testified or not, I can't tell you. If it doesn't say that, I can't tell you.
Q. And then it says you discussed the case with Tom Brown. Is that a typo? Is that Tom Young?
A. Probably, yes.
Q. "He and his brother are willing to go ahead with the case." Explain that sentence to me.
A. "He and his brother are willing to go ahead with the case." Mr. Tom Young. I guess what it says is what it says. He and his brother are willing to go ahead with the case.
Q. At this point in time do you know whether a lawsuit had been filed against cigarette companies?

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A. This lawsuit or other lawsuits?
Q. This lawsuit.
A. No.
Q. Did you call Mr. Young, Attorney Young, for the purpose of trying to persuade he and his brother to file this lawsuit?
A. No.
Q. Then what was the point of calling Mr. Young on May 3, 1993?
A. The point is that they were asking me whether my -- whether my review of the literature and review of this case was strong enough that it would withstand -- and try to get as much information as possible from other individuals that it would withstand --
Q. A critical analysis?
A. Yeah. Yes.
Q. You don't -- I don't mean this facetiously, I don't mean it disrespectfully. You certainly don't think it's inappropriate for your opinions to be critically analyzed in this case, do you?
A. No.
Q. Do you think -- and your opinion about the cause of Mrs. Wiley's cancer is, in essence, a judgment based on some observations, some facts, and some assumptions; isn't that fair to say?
A. No assumptions. On facts and clinical presentation.
Q. Well, you have to assume, Doctor, do you not, that Mrs. Wiley was exposed to a certain amount of environmental tobacco smoke at the VA.
A. Do I have to assume that? They told me that it was the fact. Yes.
Q. But so that's an assumption. You have to assume that to be true.
A. If they told me that was the case, that was the case.
Q. Well, but you have no way of knowing whether she was or was not exposed or to how much she was exposed beyond what you've been told. Right?
A. The family told me, or Mrs. Wiley told me how much she was exposed. The family told me how much she was exposed.
Q. And you --
A. And I have to take for granted that is the truth.
Q. And you wouldn't define that as an assumption?
A. An assumption to me means I'm assuming something that may or may not be true.
Q. Well, that's my question to you: How do you know what they have told you is true?
A. Because I can't imagine that these people, knowing that she's critically ill, knowing that she's in horrible, horrible pain, knowing that they came over here because they were concerned that she, you know, she was in -- they did not have a diagnosis, they did not know what was eating away at her bones, told tell me an untruth.
Q. How do you know what they told you is complete?
A. Because most people, when they are in this situation, if not all people -- I can't imagine -- people tell me they have AIDS, they tell me that they have -- doing other things that their families don't even know they're doing. I can't imagine, in a situation like this, that someone would tell a physician something as incomplete or, to

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their knowledge, as complete as possible.
Q. Well, you know for a fact, do you not, Doctor, that they did not tell you that Mrs. Wiley may have been exposed to radon in any of her homes.
A. They did not give that to me when I made the diagnosis, no.
Q. And you know for a fact, do you not, Doctor, that radon, the presence of radon was detected in Mrs. Wiley's home after her death, after May of 1993.
A. What's your question now?
Q. Well, do you know for a fact that the presence of radon was detected in Mrs. Wiley's home after her death, after June -- or after May of 1993?
A. I do not know that that has been detected.
Q. All right. So as we sit here today, you have no information about whether or if Mrs. Wiley may have been exposed to radon in her home or beyond what you were told or not told about it. Let me rephrase the question.
Do you have any information about the presence of radon in Mrs. Wiley's homes?

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A. My understanding, after discussing it, that we were going to check. And by hearsay my understanding was that there was no radon found.
Q. Okay. So we, after discussing it with Dr. Repace --
A. Yes.
Q. -- you suggested to we, being the lawyers --
A. Yes.
Q. -- that they should check to see if there's radon in the home?
A. Yes.
Q. And they told you there was not.
A. My understanding, later on -- my understanding is they were going to check. And my understanding, later on, that there was no radon found.
Q. Okay. Because if there was radon found, that might affect your opinion or -- well, your opinion about the cause of her disease.
A. Would it affect it?
Q. Might it affect it?
A. Might have affected it? Given the numbers involved with radon deaths and given the numbers with environmental tobacco smoke, it

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would be, you know, an endobronchial lesion like this, I still would be of an opinion that environmental tobacco smoke most likely is the cause, even, you know --
Q. What if you're wrong about the numbers? What if exposure to residential radon is associated with a higher number of lung cancers in this country than exposure to environmental tobacco smoke? If that were the case, would the presence --
A. In a smoker.
Q. In a nonsmoker. If that were the case, would the presence of radon in Mrs. Wiley's home affect your opinion about the cause of her disease, or be something you would have to consider in determining whether you could attribute her disease to exposure to environmental tobacco smoke?
A. I would have to consider it.
Q. Now, the next sentence in Exhibit -- is it 19?
A. Uh-huh.
Q. -- says, "If we can control the amount of litigation that the tobacco industry will throw at us, we may have some hope." Would

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you explain that sentence to me.
A. Well, if we can control the amount of litigation, the amount of money, and changing the facts, and -- we may have some hope. Essentially what it says.
Q. Well, do you deny the companies who have been sued in this case the ability or opportunity to defend themselves --
A. No.
Q. -- and dispute the case?
A. No.
Q. Do you deny -- what is it about the amount of money that -- I mean, what do you mean, the amount of money?
A. Well, you guys make a lot of money. I mean, you're very highly paid lawyers. Tobacco industry makes billions of dollars off of people's addictions every year. And you have a lot of money to hire people you want to hire, to change reality. So to speak.
Q. Well, let me ask you this, Doctor. What reality do you think has been changed in this case?
A. I don't know. I have not seen any other witnesses. All I know is from what's

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happened before on other litigation cases, I'm not an expert. I'm not a lawyer. I know what I read, and I know the medical literature.
Q. Are you suggesting to the jury that a witness who testifies in a case like this on behalf of a cigarette company shouldn't be believed?
A. I think the jury needs to look at all the evidence and look at what makes the most sense in each case.
Q. And that relates to your testimony as well, doesn't it?
A. Yes.
Q. Do you think -- well, let me ask you this: Do you think Mr. Cross makes more or less money than some of the rest of us over here?
A. I have no idea.
Q. Well, and I ask a question like that in all seriousness. Just because a tobacco company has money to hire lawyers doesn't necessarily mean that they've hired better lawyers than Mr. Wiley has, does it?
A. No.
Q. You're not suggesting that Mr. Wiley's

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lawyers aren't as enthusiastic and as contentious and as hard working as the lawyers that have been hired to represent the companies their client has sued in this case, are you?
A. No.
MR. FURR: You may want to note how many are present today for the record.
Q. In fact, there's six of them; right?
A. Yes.
Q. And one, two, three, four, five, six, seven, eight of us, but there are eight different companies who have been sued in the case; right? So they have more lawyers per person than we do; right?
A. I guess so.
Q. Okay. Hope of what is the question. My next question. "We may have some hope." Hope of what?
A. Success.
Q. And how do you define success in this case?
A. Success to me means -- would mean that the individuals or companies that allowed her death to occur would be held liable.
Q. And what facts do you think establish that

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liability?
A. The cause of death, her exposure, her clinical history.
Q. Doctor, what effort did you make in May of '93 to -- well, let me rephrase the question.
You used the word, I might have used the word, we both, I think, used the word "truth" when we were talking about the history that was provided to you.
You assume people give you complete, accurate, truthful information. What effort have you ever made in connection with this case to assemble enough information to find the truth in this case?
A. What efforts have I made.
Q. Let me rephrase the question. Is this the kind of situation where it's possible to find the absolute truth? I mean, is there a way to prove unequivocally that this woman's lung cancer was caused by exposure to environmental tobacco smoke beyond any doubt?
A. I believe there is.
Q. How would you do that?

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A. Again, I'm not a biochemist, but I do know that there are markers that occur in the tissues. Her exposure, her past medical history, the presentation, the fact that there was an endobronchial lesion, the fact that there is no other explanation. You know.
Q. But see -- and I understand what you're saying, but that's my point. I'm trying to get away from no other explanation to I can put my finger on this and prove beyond doubt that this is the reason something happened. I mean, there are times, I take it, in your profession where you can do that. There are times where you can't. I'm just asking you, where does this situation fall on that continuum? I mean, you know --
A. I feel that this case, this lady died as a result of environmental tobacco smoke. That's what I -- that's what I feel. That's what I felt back in '91. That's what I've felt for the last seven years.
Q. And my question is, Is how would one go about --
A. I just answered your question before.

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Q. Okay, just --
A. There are markers in the tissues.
Q. Right. Let me ask you this then: Do you know whether those markers are specific to tobacco smoke or whether they are indicative of exposure to other substances that occur in other aspects of our lives?
A. Well, in my reading, and this has been some time ago, I understand that there are markers that can occur where they identify certain chemicals that come off environmental tobacco smoke that can be picked up in tissue.
Q. And my question, Doctor, is do you know whether those chemicals are present or found in other things like air, air pollution, food, water --
A. Not food.
Q. -- other substances?
A. Not water. It has to be an inhalation. And since one of the major causes of environmental pollution in, especially in the house -- not in the house, in offices, et cetera, are -- or in the house, is environmental tobacco smoke, you know --

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Q. Can you tell me, Doctor, what chemicals in environmental tobacco smoke are unique to environmental tobacco smoke?
A. Well, I have to look at my picture here, but pyrene, benzopyrenes -- I'm not a chemist, but --
Q. Let me stop you there. Is it your testimony that benzopyrene is found in nothing other than environmental tobacco smoke?
A. I'm not saying it's not found other places. I'm not a biochemist, I'm not a pollution expert, but I do know it's indoor air, it's environmental tobacco smoke, it's one of the markers.
Q. My question, Doctor, is, can you tell me -- and I appreciate you've got some notes, we'll mark those later, so I don't want to -- if it's in the notes it's in the notes.
A. Yes.
Q. But can you tell me whether there are any chemicals in environmental tobacco smoke that are so unique to environmental tobacco smoke that you can say if I find that chemical I can be sure that somebody smoked

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a cigarette here as opposed to somebody drove a car through here or somebody opened a window here or somebody -- you know what I'm saying?
A. Well, there's nicotine, that comes from cigarettes. Or formaldehyde, but there's other things with formaldehyde.
Q. That's my question. Tell me what substances are in environmental tobacco smoke that only come from environmental tobacco smoke.
A. I would say probably nicotine. The other ones I can't tell you.
MR. OHLEMEYER: Let's mark this as the next in order. This is No. 20.
(Deposition Exhibit(s) 20 marked for identification.)
Q. Doctor, this appears to me to be a draft of the letter you wrote in July of 1993 about Mrs. Wiley and her lung cancer. Does that make sense?
A. Yes. I'm not sure if this is the final -- I don't know. If this is the final letter or a draft, I can't tell you.
Q. I can assure you it's not. That's what we're going to talk about. You wrote a

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letter on July 20, 1993, that you signed re: Mildred Wiley addressed To Whom it May Concern.
A. This is June 7th, the one I have.
Q. I know.
A. Okay.
Q. So this was written before the July 20th letter; right?
A. June 7th was written before the July 20th letter.
Q. And the letter you wrote in July of 1993 was in response to a request from the Department of Labor for information about Mrs. Wiley's death with respect to her employment. Do you recall that?
A. If you have it there in front of you, I don't have it in front of me.
Q. I thought we had it somewhere, but, I mean, I'm just reading from it so you don't -- my question to you is: Why did you write this letter and who asked you to write it and when were you asked to write it?
A. Well, I wrote the letter at the request of probably her attorneys. Mr. Wiley's attorneys. Because I believe that they were

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attempting to get some type of -- let's see here. I believe he was -- I believe he was applying for some type of benefits or something from her, because of her employment. That's my understanding.
Q. Did you draft a copy of that letter before June of 1993?
A. I can't be certain. If I don't have it in front of me I can't be certain.
Q. Do you recall how many drafts of that letter you went through before you signed it?
A. I don't know. Probably one or two maybe. I don't know.
Q. From whom did you get the information that you incorporated into the letter?
A. From my literature search. And from the hospital chart.
Q. Did you get any information from the plaintiff's lawyers?
A. I don't recall that I did. Unless it's stated in there.
Q. Well, let me hand you a copy of that July 20th letter.
A. Yes.
Q. And see on the back, page 5, your signature?

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A. Yes.
Q. So this is the one you signed and gave to the plaintiff's attorneys.
A. Yes.
Q. You see on page 3 where there's a description of the 1986 Surgeon General's Report, that third paragraph?
A. Third paragraph.
Q. This report was prepared by --
A. Department of Health and Human Services.
Q. Is all the information in that paragraph about the chemistry of environmental tobacco smoke information you obtained from that Surgeon General's Report?
A. This report was prepared by the Department of Health and Human Services. Let's see here. It says "In 1986 in a report of the Surgeon General entitled "The Health Consequences of Involuntary Smoking' it was stated that involuntary smoking is the cause of disease including lung cancer in healthy nonsmokers.
"This report was prepared by the Department of Health and Human Services with contributions from numerous scientists. It

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states that ETS results from the combination of side stream smoke..." what's your question then?
Q. My question, if you see in the next paragraph, it says, "In summary then, in this report"; is it fair to say that the information in the paragraph between your citation and between your summary paragraph is information you obtained from that report? I'm just trying to figure out where you got that information.
A. Well, most likely it was, although I had a number of other articles that I was reviewing at the same time. Most likely what I did is I looked at the Surgeon General's Report, they have a number -- they have a bibliography back there, I followed that and got additional reports from the bibliography as well.
Q. Now, between June of '93 and July of '93 you made some revisions to this letter. My question, Doctor, is tell me, describe the process by which you made those revisions.
A. Well, it may have been that I may not have been specific enough. And I would suspect

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that's the -- the reason why the revision, I wanted to make sure everything was crystal clear.
Q. What do you mean by not specific enough?
A. Perhaps there was some areas that was not adequately explained or definitive enough.
Q. Well, how did you make that determination?
A. Most likely the attorneys may have read this and came back to me and said we need to make this a little bit more specific.
Q. So you prepared the June 7th letter and in all likelihood sent it to the lawyers --
A. Uh-huh.
Q. -- and then worked with them to prepare the July 20th letter?
A. Not worked with them. They may have made some recommendations. Since I have not written a letter to OSHA before and I suspect they have, they were helping me be as clear as possible. We were -- we essentially are -- I mean, I felt that I was writing for Mrs. Wiley. I was essentially helping her and her husband.
Q. But they were certainly providing some information or assistance to you in

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preparing the letter.
A. Not literature, no.
Q. Well, I mean editorial.
A. No. They were specifically saying to me, they may have read the letter and said you need to make this more specific. This is my recall of this.
Q. Did they tell you to delete anything from your June draft?
A. I can't recall.
Q. Let's look specifically on page 2 of the June draft.
A. Okay.
Q. Which is Exhibit 20. You see the last sentence of the paragraph that begins "this patient"?
A. Okay. "This patient had no other exposure."
Q. See the last sentence begins "Since"?
A. "Since this patient had no other source of known carcinogen including the fact that radon levels in her house were extremely low or non-existent by history..."
Q. I'm going to stop you right there. Tell me what that sentence means, "radon levels in her house were extremely low or non-existent

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by history."
A. It was probably, by that time, if that's what it says, is that I was given the history that the radon exposures were extremely low or non-existent.
Q. Who gave you that history and on what basis did they give it to you?
A. Most likely it was given to me by the attorneys since I don't -- I have no idea where she even lived except someplace over near Marion.
Q. And you could do nothing but take their word for it.
A. Yes.
Q. Now, why didn't that sentence end up in the July 20th letter?
A. I don't know.
Q. Did they tell you to delete it?
A. Not that I'm aware of.
Q. Do you recall why you deleted it?
A. No.
Q. What did you know in June --
A. There should be no reason for deleting it.
Q. Well, I can assure you it's not there. My question is: Do you recall why it's not

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there?
A. No.
Q. All right. And the reason it shouldn't be deleted is because the issue of radon and her potential exposure to radon is something that would be very important to look at in trying to determine what caused her cancer; isn't that right?
A. Yes.
Q. Now, Doctor, the next question I have is, you see on page 2, that sentence that says "Other potential etiologies may have been..."; it's the end of that first paragraph.
A. Which letter are --
Q. Page 2, June 7.
A. June 7, page 2. Now, what?
Q. Last sentence of that last paragraph, "Other potential etiologies may have been breast or pancreatic"?
A. Yes.
Q. That thought, those four sentences aren't in your July 20th letter. Do you know why these sentences were deleted from that letter?

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A. No.
Q. Do you know whether the attorneys suggested you delete those sentences from that letter?
A. No, because it would seem to me like that should have been in the -- I mean, it just makes a stronger case.
Q. Well, can you -- by the way, who typed this letter?
A. Probably Delores, one of our typists.
Q. So you don't have any recollection as to why those sentences were deleted from the July 20th letter.
A. No.
Q. Now, you see on the bottom of the page, first page of the June 7th letter --
A. Yes.
Q. -- it says "The patient was critically ill when she was admitted"?
A. Let me see here. Where is this at?
Q. Bottom of the page.
A. Bottom of the page? Page 2.
Q. Page 1.
A. Okay.
Q. "Patient was critically ill when she was admitted to the hospital; she was having a

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great deal of difficulty giving a complete history"?
A. Yes.
Q. Now, in your admission note, you don't make any reference to any difficulty Mrs. Wiley had in giving a history to you, do you?
A. Probably not. If it didn't say it there.
Q. And in the July 20th letter, you don't make any reference to any difficulty Mrs. Wiley had in giving you a complete history.
A. If it's not there, it's not there.
Q. Do you know why it's not there?
A. No.
Q. I mean, is one of the reasons it's not there because she wasn't having a great deal of difficulty giving you a complete history?
A. I can't tell you that. I'm not going to lie. I'm not going to lie.
Q. I'm not asking you to lie, Doctor. I'm asking you to tell me whether the reason you did not include a reference to any difficulty Mrs. Wiley may have had in giving you a complete history in your July 20th letter is because she, in fact, did not have a great deal of difficulty giving you a

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complete history as evidenced by your admission note.
A. Well, if it's not --
MR. CROSS: Why don't you let the witness have an opportunity to look at the document, make sure that it's there or not there.
A. I mean, the point is that you're --
Q. My point is this, I guess.
A. You're being nit-picking.
Q. If it's not in the admission note it's not there.
A. Right.
Q. If it's not in the admission note, it's not an observation that you thought was important to the diagnosis and treatment of Mrs. Wiley.
A. Yes.
Q. Okay. So now let's go to page 2 of the July 20th letter. See at the top of page 2?
A. Yes.
Q. Says "bilateral pleural effusions"?
A. Yes.
Q. Are bilateral pleural effusions a marker of asbestos exposure?

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A. No.
Q. Are they a symptom of an asbestos-related lung disease?
A. They could be if the history was such and you had calcification on the lung.
Q. Does the EPA believe that asbestos is a group A carcinogen?
A. Yes.
Q. Does the EPA believe there is a safe level of exposure to asbestos?
A. I would suspect there is not. But I can't be certain since I'm not an expert on that area. But I would suspect there is no safe level or they wouldn't have torn it out of hundreds of schools.
Q. What do you know about Mrs. Wiley's history of exposure to asbestos?
A. Well, she, as far as I know, she had none.
Q. What effort did you make to determine whether there was pathological evidence of asbestos in Mrs. Wiley's lungs?
A. Well, in the biopsy as well as the autopsy report there was no clear evidence of asbestos in the lungs itself. They would have picked that up at micropathology.

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Q. Well, isn't it more accurate to say that the pathologist examined iron stains of four sections of the lung, taken on autopsy, to determine whether or if there were asbestos bodies present?
A. I need to look at -- since you're reading something I just want to make sure I'm --
Q. Well, let me ask you, you don't have -- I mean, that's not a subject with which you have --
A. All I know is my understanding is that the pathology report, they looked for asbestos bodies, there was no evidence of them.
Q. Now, Dr. Kocoshis suggested to you that lung tissue could be sent to Duke University where a more sensitive analysis could be done and that would be to quantify the presence of asbestos in the lung tissue; isn't that right?
A. Yes.
Q. Do you know whether anyone ever did that or looked at that or followed up on it?
A. I cannot tell you whether it was done or not.
Q. Let me show you what was marked as Exhibit 7

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at Dr. Songer's deposition. Can you tell me whose handwriting that is?
A. Mine.
Q. Okay. Thank you.
MR. FURR: Excuse me. Before you go on, I don't think you marked the July 20th letter.
MR. OHLEMEYER: That's right.
MR. FURR: It may have been marked the last time, during the first deposition we took.
MR. CROSS: No, it wasn't.
MR. FURR: It was not.
THE WITNESS: Says Exhibit 2.
MR. OHLEMEYER: That's from something else. I haven't, but I'll get to it. We might as well mark it, go ahead and mark it next in order.
(Deposition Exhibit(s) 21 marked for identification.)
Q. Doctor, do you know or remember when you wrote this little note on Exhibit 7?
A. No. Most likely it was about the time that I received this. Which is November -- I mean, I may have received it after November

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24, '93.
Q. All right.
A. Her clinical presentation was not consistent with that. I mean, she had no calcium in her lung, there was none in the x-ray.
Q. But at some point, Doctor, two years, two and a half years after Mrs. Wiley's death, you suggested to Dr. Songer, or you inquired of him do you think we should look at this further.
A. Yes.
Q. "This" being the quantification of asbestos at Duke University.
A. Yes.
Q. And you don't know if anyone ever did that.
A. I'm not -- I do not have any recall whether anyone did that. It was down -- I mean, with her clinical presentation and the fact that we had autopsies, I mean, it was -- that was not even in the differential.
Q. Well, November 24, 1993, the differential, as you described it, has nothing to do with Mrs. Wiley's treatment; right?
A. Right.
Q. I mean, November 24, 1993, has to do with

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the lawsuit that you and the lawyers have been discussing and some of the other entities we've discussed already; right?
A. Has to do with the fact that whether this case was consistent and could be brought forth -- could go forward for this situation.
Q. One way to critically analyze your opinion would be to conduct that type of analysis to determine whether or not there was asbestos in Mrs. Wiley's lungs.
A. That would be one way.
Q. Another way to critically analyze your opinion would be to measure and record the amount of radon that might be present in a home in which Mrs. Wiley lived.
A. Yes.
Q. Another way to critically analyze your opinion would be to compare Mrs. Wiley's history of exposure to the history of exposures given in groups of people who have been studied in epidemiological studies, who have demonstrated either an increased or a not increased incidence of lung cancer.
A. In what situation now?

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Q. If we took Mrs. Wiley's history and we compared it to the histories that are contained in epidemiological studies, one way to critically analyze your opinion would be to see whether a history like Mrs. Wiley's was correlated with an increased risk of lung cancer in those epidemiological studies.
A. And epidemiological studies having to do with what?
Q. With individuals who are nonsmokers who were exposed to environmental tobacco smoke.
A. You switched gears now.
Q. I'm sorry, but I'm right. Well, I shouldn't say that. Am I correct?
A. You've asked that question before.
Q. I thought I had, I wasn't sure.
A. You have.
Q. One way to critically analyze your opinion would be to compare her history of exposure to history of exposures of individuals who have been described as nonsmokers in epidemiological studies to see whether there's an increased incidence of lung cancer in those types of people.

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A. I don't understand your question. Because what you're saying is nonsmoking.
Q. Well --
A. Does that mean they're exposed to secondhand smoke as well or not --
Q. Let's back up. If I'm a cigarette smoker and I have lung cancer --
A. Yes.
Q. -- one way to arrive at an opinion about the cause of my lung cancer is to look at epidemiological studies of people who have a history of cigarette smoking. And you say, Well, gee, if people with a history of cigarette smoking have an increased incidence of lung cancer, then I'm suspicious that this man with this history might have a lung cancer associated with that history; right? I mean that's just -- that's part of the process.
A. Yes. The studies have been done that those who smoke have an increased risk and the duration and the level of exposure they have to tobacco smoke tells us whether they have an increased risk -- or they do have an increased risk; tells us how much of an

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increased risk they do have.
Q. And one way to critically analyze your opinion about the cause of Mrs. Wiley's disease would be to look for studies, epidemiological studies --
A. Yes.
Q. -- of nonsmokers that have been done that describe histories of exposure similar to Mrs. Wiley's history of exposure and to determine whether those groups of people demonstrate an increased incidence of lung cancer.
A. Yes.
Q. Okay. Doctor, let me ask you to pull out Exhibit 3 from your deposition.
A. Which one is that?
Q. That's the one that says Exhibit 3. I'm sorry. Tell you what, do you mind, let's mark those notes as the next in order. And then maybe we can make a copy during lunch.
THE WITNESS: Put your notes in as an exhibit, too?
(Deposition Exhibit(s) 22 marked for identification.)
(Discussion off the record)

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Q. Exhibit 3, Doctor, previously marked --
MR. WAGNER: So did we mark her notes as an exhibit?
MR. OHLEMEYER: I'm sorry, 22.
Q. You've had a chance to review this since our last session?
A. I've read it.
Q. It's a dictation created by you on or about May 24, 1993 --
A. Yes.
Q. -- describing a discussion you had with a number of people including Dr. Songer.
A. Yes.
Q. You talked with Dr. Songer about the diagnosis of lung cancer as it relates to Mrs. Wiley; right?
A. Yes.
Q. And at the time you talked to him, did he tell you that he was reluctant if not unable to get up on a witness stand and state that this unequivocally was a primary lung cancer?
A. What he stated was, until he evaluated the case more and looked at the literature, looked at what we had, he wanted to make

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sure that he could get up on the witness stand and truthfully state that that was his opinion.
Q. So as of May 24, 1993, Dr. Songer told you he was unable to truthfully state that in his opinion Mrs. Wiley suffered from a primary carcinoma of the lung.
A. He stated that he was unable to unequivocally state that that was lung cancer because of the elevated CA15-3.
Q. And CA15-3, as he told you, might indicate a primary breast cancer.
A. But it was nonspecific. And may also indicate pancreatic or lung cancer.
Q. So then you got off the phone with Dr. Songer and called Mr. Riley.
A. Yes.
Q. And you asked him if there were some pathologists he could recommend to you to look at the slides in this case.
A. I don't know if recommend to me or not. But what we wanted to do is, again, we were looking at this case to see if this was a strong case that could go forward.
Q. They weren't interested in going forward

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with a weak case.
A. Well, would you?
Q. Well, sometimes I have to. They get a choice.
A. Well -- I mean, we want to try to make sure that this case, after critical evaluation, as you state, looked at everything and the expert witnesses would come up with the same determination.
Q. So you were looking for people who would confirm your opinions or suspicions about the cause of her cancer.
A. What we were looking for -- and I truly believe this and remember this -- what we were looking for is we would let them see the pathology slides or whatever, look at the case, and come back to us and state this is unequivocally related to primary lung. Which is what we did.
Q. And one of the things that Dr. Kocoshis suggested to you was that -- Dr. Kocoshis did the autopsy; right?
A. Yes.
Q. That although he felt the tumor from the slides is probably related to lung cancer,

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that it was possible it could have been a breast or a pancreatic primary given the elevated CA15-3.
A. It says, "the tumor from the slides is probably related to lung cancer, but given the elevated CA15-3 possibly breast or pancreas."
Q. That was what Dr. Kocoshis told you?
A. Yes, but I do not recall whether he had looked at the entire case or was just looking at this. Knowing Dr. Kocoshis, he probably looked at the case -- looked at the slides, and with all the thousands of other slides he looks at and all the other thousands of cases he's contended with, that he had not looked at everything.
Q. Well, his job, typically, as pathologist, isn't it, is to look at the slides.
A. Yes.
Q. And let other doctors like you look at the clinical.
A. No. Not really. I mean, pathologists read the chart. I mean, if they come in and look at -- if somebody's anemic and a pathologist that does the bone marrow evaluation will

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look at the bone marrow but also go back to the case and make sure everything fits together, or they're not a very good pathologist.
Q. Well, how many times has Dr. Kocoshis come to you with an opinion about the cause of cancer that he has observed in an individual?
A. A number of times.
Q. And what does he tell you?
A. What his best opinion is regarding the slides, the biopsy reports, and the case.
Q. Well, what did he tell you in this case on May 24, 1993?
A. That, from looking at the slides, I -- and he felt that the tumor from the slides is probably related to lung cancer, but given the elevated CA15-3 possibly breast or pancreas.
Q. So is it fair to say he wouldn't rule out the possibility of a breast or pancreatic primary?
A. That's what he said. He could not rule out from the slides -- not from the slides, but the CA15-3.

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Q. And he suggested to you the work at Duke that was repeated again in November of 1993.
A. Other individuals -- Duke University has a specialist in asbestos, that he would -- could do a quantitative analysis of the slides to tell how much asbestos Mrs. Wiley was exposed to.
Q. Now, do you recall talking about this case with Dr. Triplett, or was it Mr. Riley that talked to Dr. Triplett?
A. I believe I talked to Dr. Triplett.
Q. And did Dr. Triplett tell you that it was unusual to find peripancreatic tumor in the absence of a primary pancreatic tumor?
A. It is unusual to find peripancreatic in the absence of primary pancreas, yes.
Q. Did he tell you the fact there was pancreatic involvement made him suspicious of a primary pancreatic tumor?
A. No, that's not what he said. He said the fact that there is no primary pancreatic cancer makes you most likely -- very, very strongly suspicious that this is a primary lung that was metastatic to the peripancreatic tissue.

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Q. But did he tell you that it would not be unusual to find peripancreatic cancer tissues if you had a primary pancreatic tumor.
A. Repeat that.
Q. Here's what I don't understand. As I read this, it appears that Dr. Triplett suggested that there was something remarkable or unusual about the peripancreatic involvement.
A. Not really. I mean, the fact that it -- I mean, it would make most sense, if this was a primary pancreatic cancer, then you would have found it in the pancreas, you would not have found it just in the peripancreatic tissue. And that would go along with a metastatic lesion from the lung.
Q. But would it also go along with a primary pancreatic tumor that grows into the peripancreatic?
A. That's not what you have here.
Q. We'll get to that.
A. No, you don't do that. You don't have --
Q. You don't have -- what do you mean you don't have it here? You don't have a pathologist

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who has told you that?
A. We had an autopsy report that went through the pancreas and said there was no pancreatic cancer. I'd have to look at it again, but this is just peripancreatic. And the CAT scan would go along with that as well.
Q. And what happens at the autopsy is the pathologist takes some tissue from an organ --
A. Yes.
Q. -- puts it on a slide --
A. Yes.
Q. -- looks at it.
A. Well, he also looks at it grossly.
Q. Correct. Looks at it microscopically?
A. Grossly and microscopically and --
Q. And then makes a judgment as to whether he or she sees an abnormality or not.
A. Yes.
Q. And in this case, Dr. Kocoshis doesn't describe or does describe an abnormality in the pancreas.
A. It says the pancreas -- this is from the autopsy report, this is Dr. Kocoshis. It

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says, "The pancreas is appropriate in shape and size with respect to total body fat stores. On cut surface, it is lobular with interspersed fat without focal calcification, fibrosis, hemorrhage or fat necrosis. Autolysis is not significant. There is a possible metastatic tumor in the peripancreatic lymph nodes." That is not in the pancreas itself.
Q. Now, if we wanted to critically analyze Dr. Kocoshis's opinion, we could take the slides and have a well-trained pathologist look at them and see if he or she agrees with that: right?
A. You could do that.
Q. All right. Now, Doctor, is it more common for primary carcinoma of the pancreas to metastasize to the lung or for a primary carcinoma of the lung to metastasize to the pancreas?
A. I can't tell you those statistics. Pancreas or pancreatic tissue?
Q. Pancreas.
A. Well, it's very uncommon, I would think, that a primary lung would not go -- I mean,

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it's possible, I guess -- go to the pancreas as well as the pancreatic tissue.
Q. Okay.
A. But most likely it's just peripancreatic.
Q. But is it more or -- what's more common, a primary carcinoma of the lung metastasizing to the peripancreatic lymph nodes or a primary carcinoma of the pancreas metastasizing to the lung?
A. The common numbers? I can't tell you that. it depends on the population. My point is, is that pancreatic cancer could metastasize to the lung, but that -- but more likely the alternative is, is lung cancer would go to the peripancreatic tissue.
Q. Well, my question is specifically that, Doctor: What's more common, a primary carcinoma of the lung that --
A. I can't tell you the numbers.
Q. Okay. And the numbers aren't unimportant, are they, to you as a doctor in trying to determine the primary site of some of these cancers, are they? When you say the numbers --
A. The numbers are important. But you're kind

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of confusing things. Or maybe you're confused. But the point is, is that lung cancer most likely would go to the peripancreatic tissue. If it was a primary pancreas, it would go the other way. You see my point?
Q. Yes. And my question to you, Doctor, is, what's more common, a tumor in the lung metastasizing to the pancreatic tissue, or a tumor that starts in the pancreas metastasizing to the lung? I think you keep telling me you don't know; that's fine.
MR. CROSS: Are you talking about the pancreatic tissue or the peripancreatic?
THE WITNESS: Peripancreatic tissue.
Q. No. I'm talking about the pancreas. A primary pancreatic cancer.
A. An oncologist would be able to tell you this for sure but I have not seen where a primary lung in my experience has gone from the lung to the pancreas.
Q. I don't want to interrupt you. I'm not talking about your experience. I'm talking about the collective experience --

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A. Well, you'll need to go to an oncologist to talk like that. To talk about that.
Q. And my point though, and I want you to agree or disagree with me, the collective experience of other doctors is not unimportant to you as a clinician in trying to determine an appropriate diagnosis and a site of a tumor in somebody where there's some uncertainty about it.
A. No, it's very important.
Q. Doctor --
A. But let me clarify again, the autopsy report -- I mean, the autopsy is the ultimate biopsy. Okay? It is the ultimate biopsy of a patient. There is no primary pancreatic cancer in this autopsy report.
Q. But you agree with me that if I wanted to critically analyze Dr. Kocoshis's opinions about that, I could just have another pathologist or two or three or four look at the slides and see if he or she agrees with him.
A. Yes, you could.
Q. And you certainly are aware of the fact that there is some inter- and intraobserver

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variability in the analysis of pathological specimens?
A. You look at the evidence, you see what is most likely the etiology or the diagnosis. And you look at -- I mean, you look at what most likely -- I mean, there is no reason Dr. Kocoshis should lie on this.
Q. Dr. Turner, I have not suggested, nor have I asked you whether Dr. Kocoshis lied. My question to you, I can either have the court reporter read it back --
A. I understand the question.
Q. And it can be answered yes or no or I don't know. Isn't it a fact that there is inter- and intraobserver variability in the analysis of pathological specimens?
A. It would seem to me like when he's doing the autopsy report, if there was any question that there was changes there that he would even question, he would have had -- I mean, there is how many pathologists over at Ball Hospital; ten, eight? I don't know how many there were back then, eight or ten.
I know for sure that if there was any question about those slides, he would have

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called up and said, Dr. Branham, come down here and look at this. I want to make sure, because when I make a diagnosis, I want to make sure. I mean, this is a legal document. He would have had other people look at the slides.
MR. OHLEMEYER: Would you read back my question, please.
A. The question is, is there inter- --
Q. -- and intraobserver variability in the analysis of pathological specimens.
A. There can be.
Q. And in fact, Doctor --
A. Was there in this case?
Q. Well, that's my question. I guess if we're going to do a critical analysis of Dr. Kocoshis's opinions, the fact that another pathologist may disagree with him does not in and of itself suggest to you that they are either wrong or believe Dr. Kocoshis to be a liar, does it?
A. I think it has to do with their training, their background, their experience. And looking at the entire picture.
Q. And the entire picture that a pathologist is

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looking at when he or she is diagnosing a pathological specimen is in the microscope: right?
A. Not always. They look at the entire picture. They look, I told you before, they look at the history. I mean, if there's any question, they go back, read the chart, look at the -- I mean, they've called me and said, Is this chest x-ray or -- I mean, what did the bone scan show, and then they -- everything has to fit together.
Q. Doctor, what did Dr. Kocoshis conclude was the cause of Mrs. Wiley's adenocarcinoma of the right lung? And I'll refer you to page 5 of his report.
A. Page 5 of his report.
Q. Here, I've got it in my hand.
A. He does not state.
Q. In fact, there's a slot right there that says --
A. That's often left -- I mean, they --
Q. Here's my question, Dr. Turner.
A. Yes.
Q. It says "Immediate Cause of Death: Adenocarcinoma of the right lung"; right?

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A. It says adenocarcinoma of the right -- colon right lung. "Immediate Cause of Death --"
Q. Colon.
A. Yeah, colon.
Q. Adenocarcinoma.
A. But it's not like colon like colon bowel.
Q. It's punctuation.
A. Yes.
Q. Immediate Cause of Death, colon -- that trick doesn't work. I've tried that. I'm being facetious. "Immediate Cause of Death: Adenocarcinoma of the right lung."
A. Yes.
Q. "Due to:" Blank.
A. And there's nothing there.
Q. And it says, "Other Conditions: Bilateral pleural effusions."
A. Yes.
Q. Do you know why Dr. Kocoshis thought that was remarkable or noteworthy?
A. Bilateral pleural effusions, you'll have to ask him. Oftentimes they put down things that they remember and are trying to bring out.
Q. Couple more questions, we'll break for

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lunch.
Exhibit 3, you still have that in front of you?
A. Exhibit 3, yes.
Q. It says, the bottom of that paragraph that begins Mr. Riley, "A gross evaluation of the breasts was completed with palpation, and this was negative." And in layman's terms that means the breasts were looked at by the pathologist conducting the autopsy and he felt them or touched them and didn't feel any abnormalities; right?
A. No, it doesn't mean that.
Q. What does it say?
A. It says -- okay, okay, okay. Now, this is during -- okay. Dr. Triplett, pathologist, did review the slides. It was -- "In reviewing the autopsy report, however, the pancreas was normal with the exception of peripancreatic metastatic tissue. This would be pretty unusual if they did not find a primary pancreatic tumor inside the pancreas and just not on the peripancreatic lymph nodes. The stomach was looked at and was negative. The bowel was looked at and

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was negative. A gross evaluation of the breasts was completed with palpation --" so the pathologist palpated the breast.
Q. What does palpated mean?
A. They felt the breasts. "And this was negative."
Q. What does negative mean?
A. Negative means negative. It means that it was -- they did not palpate any abnormalities.
Q. All right. But nobody sectioned the breasts and looked at them under the microscope, did they?
A. There would be no need to. I mean, they don't do slices through breasts if, I mean, if there's no need to.
Q. Well --
A. And you could ask Dr. Kocoshis --
Q. -- how do you define need?
A. You could ask Dr. Kocoshis why he did not do slices through the breast. He was the pathologist; he was doing the autopsy.
Q. Well, would you, as a clinician, expect a pathologist conducting an autopsy in a woman with an elevated level of CA15-3 who was

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treated with a hormone used to treat primary carcinoma of the breast in an exercise designed to find the primary tumor to have sectioned the breasts?
A. If there was still a question and if the adenocarcinoma on the pathology slides was suggestive of breast cancer, yes, they would have sectioned the breasts.
Q. And there's no way to critically analyze Dr. Kocoshis's palpation, is there?
A. Well, I suspect he's palpated thousands of people. Thousands of females as well as males.
Q. But my point, though, I don't mean to be facetious, there's no way for anyone else to do that same palpation and see if they agree or disagree with Dr. Kocoshis.
A. Well, the point is that they were palpated before. This lady was a nurse, so she would have, I'm sure, have done -- I mean, she would have known what we were doing. Dr. Sprunger evaluated her breasts; I evaluated her breasts; Dr. Songer, who is an expert on breast cancer, I mean, that's what he primarily does, one of the things he

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primarily does, evaluated the breasts. If there was any question that there was a nodule there, they would have sectioned those breasts.
Q. But my point is, is the only way any of us can critically analyze that question would have been for somebody to section the breasts and create slides that pathologists could have looked at.
A. I don't think so.
Q. Well, I mean -- I mean, if -- we have to take -- I mean, and I don't -- the point is, we have to take your word, Dr. Sprunger's word, and Dr. Kocoshis's word, but we can't critically palpate or critically analyze those opinions because there's nothing for us to review; right?
A. This is -- okay, this lady died, okay? Let's look at the scenario here. This lady died. From all the information that we had, including the fine needle aspiration, this was a primary lung cancer. All the other evidence that we had pointed to a primary lung cancer. Why would we do -- I mean, I suspect -- and you'll have to ask

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Dr. Kocoshis this -- that all the evidence pointed to a primary lung cancer. Therefore, he did not do it because -- I mean, how was he to know that this was going to end up in a lawsuit, or whatever this is, seven years later. Okay? He did what was normal at the time. This was not a conspiracy or anything else.
Q. Dr. Turner, this is not a lawsuit that involves a claim that you or Dr. Songer or the hospital failed to perform at a level of reasonable care.
A. I know. We didn't.
Q. This is a forensic exercise where we are, in hindsight, going back and trying to determine what information you had and when you had it and when and how you formed your opinions.
And my question to you is, is there -- there is, regardless of how experienced these doctors are and how much you trust them and how much we all might come to conclude that they're experienced doctors, there is no way for anyone to critically analyze that breast tissue for the presence

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or absence of tumor because they weren't sectioned. Isn't that right?
A. There is no way that we can go back and say there was not a primary cancer there; is that what you're asking?
Q. No. There is no way for any of us to critically analyze the statement that a gross evaluation of the breasts was completed with palpation and this was negative, because we have no pathological material, no breast tissue, that we can look at under the microscope.
A. I don't think that's true because of the number of palpations of that breast tissue. I mean, I was just looking here at the colon. I mean -- I mean -- I mean, you don't, if -- if the direction is not there, you -- you'll have to ask Dr. Kocoshis why he did not do this, but that is not unusual.
Q. Did you ever order a mammogram in this case?
A. She was too sick.
Q. So the answer is no, you did not order a mammogram.
A. Plus the fact she had one in September or October, I believe, of '90.

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Q. The answer to the question is, no, you did not order a mammogram?
A. Did not order it because she was too sick and the fact she had just had one within the last year. And that my palpation was negative, Dr. Sprunger's palpation was negative, Dr. Songer's palpation was negative.
Q. You see in down here in Exhibit 3 where it says you talked with Dr. Kocoshis and asked him who else would look at the slides?
A. Yes.
Q. Why did you want someone else to look at the slides?
A. For critical evaluation.
Q. And who did you have look at them?
A. I can't remember.
Q. And what were the results?
A. Well, we had -- my understanding is I sent them to a physician or pathologist down at one of the hospitals down in Indianapolis and they looked at the slides and they looked at the clinical history and came up with the diagnosis of primary lung cancer, adenocarcinoma of the lung.

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Q. And who was that?
A. I can't remember their name.
Q. Did they send you a report?
A. I don't -- they didn't send me a report, no.
Q. Did they send you any report about -- have you ever been -- have you ever talked with them about their findings?
A. When they called me on the phone.
Q. What did they tell you?
A. That this is unequivocally primary lung cancer due to adenocarcinoma.
Q. Now, then you had a talk with Dr. Songer. By the way, did you ever ask anyone at the Mayo Clinic to look at these slides?
A. I can't remember. I may have or may not. If it's not in here, I did not talk, you know, or may have and not put it in here.
Q. Then you and Dr. Songer had a long discussion; right?
A. Yes. That's what it says.
Q. And you and he reviewed the chart to determine what Dr. Songer's frame of mind was?
A. Yes.
Q. And you were trying to determine why

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Dr. Songer didn't start aggressive chemotherapy; right?
A. Yes.
Q. Why were you trying to determine that?
A. To go through the chart and make sure that everything was completed as best we could.
Q. Well, why were you interested in determining the reason why aggressive chemotherapy wasn't started with respect to Mrs. Wiley?
A. Again, to try to make sure -- or not make sure, really. We did the best we could in the situation. I mean, this was two years after she died. We wanted to go through the chart and see what each of us were thinking and why we did what we did.
Q. Did Dr. Songer have a limited recollection of this medical case at the time you had this conversation with him?
A. I believe he did.
Q. And did he tell you that if the chart had indicated he had started aggressive chemotherapy then he would be more willing or comfortable testifying about the diagnosis of Mrs. Wiley's cancer?
A. I can't tell you that for sure. If it

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doesn't say that here I can't tell you that for sure. You'll have to ask him.
Q. Well, these are your words. It says, "If his frame of mind at the time --" the time of the treatment -- "was the fact that we were most likely adenocarcinoma, that would help him make a decision about what he could testify to." Did he tell you that if, if in this case he didn't remember, that he was using aggressive chemotherapy, then that would be more consistent with an opinion on his part, at the time, that he was dealing with an adenocarcinoma?
A. The question is -- I'm really -- I'm about spent out here.
Q. We'll take a break. This is what I want to ask you --
A. The question is -- the question is --
Q. Dr. Songer wanted to look at the chart, he wanted to talk about it with you to help determine his frame of mind at the time of the treatment.
A. Yes. Yes.
Q. Did he tell you that if the chart indicated that there was aggressive chemotherapy being

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used, then that would be more consistent with an opinion or belief on his part at the time that he was dealing with an adenocarcinoma?
A. Okay. "We are going to review the chart to see what his frame of mind was and why we didn't start aggressive chemotherapy. If his frame of mind at the time was the fact we were most likely adenocarcinoma, that would help him make a decision about what he could testify to."
Now, you're stating that if he started aggressive chemotherapy, that would be --
Q. My question to you is, yes, did he tell you if the chart indicated aggressive chemotherapy, that would refresh his recollection or indicate to him that he was treating an adenocarcinoma?
A. I can't tell you from what those statements are. I can't tell you. Did you ask him that?
Q. Not yet.
A. Okay. Well, maybe you should ask him that because, from that point of view, I mean, review the chart, see what his frame of mind

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was and why we didn't start aggressive chemotherapy. If his frame of mind at the time was the fact we were most likely adenocarcinoma, that would help him make a decision as to what he could testify to.
Now, to go from one sentence to another, I don't want to do that without knowing what I'm saying is correct.
Q. Well, you and Dr. Songer have discussed this subject, haven't you?
A. Yes.
Q. And you discussed it --
A. What subject are you talking about?
Q. Well, the subject of your treatment of Mrs. Wiley.
A. Yes.
Q. And you discussed this exhibit and these notes with Dr. Songer, haven't you?
A. I have not talked to him about this. We both have this. We both read it. But we have not talked back and forth and looked at things. I mean...
Q. Well, you both went to a meeting last week with Mr. Cross and some other lawyers, didn't you?

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A. Yes, but we don't -- I mean, we look at things from our objective. I mean, our own objective. And we don't compare notes. We don't, I mean --
Q. Let me put it this way.
A. I don't think you want us to compare notes, do you?
Q. Dr. Turner, as of May 24, 1993, is it fair to say that Dr. Songer had not expressed an opinion to you that either he believed Mrs. Wiley suffered from a primary adenocarcinoma of the lung or that he was treating her for a primary adenocarcinoma of the lung?
A. He was not treating her from at least the chart. And again, he was trying to go back and remember this chart. You know, he's very, very busy. I'm very, very busy. We have hundreds of thousands of patients. And if there was something definitive that would have said that I would have said that in this note. These notes are essentially -- I dictated them so that I could remember what was occurring at that time.
Q. And what was occurring was you talking to

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Dr. Songer. Among other things what was occurring was Dr. Songer telling you that at this point, May 24, 1993, he wasn't either comfortable or willing to testify about the diagnosis or cause of Mrs. Wiley's lung cancer.
A. For certain. Is that what you're asking?
Q. Well, I'm asking you. I mean, what was he telling you in May of 1993 about his --
A. I said, "When I talked to Dr. Songer today, he stated that he could not get up on a witness stand and state that this unequivocally was related to lung cancer because of an elevated CA15-3."
Q. But then you and he decided you were going to do something else. You were going to review the chart --
A. Yes.
Q. -- to see what his frame of mind was. What relationship did that have to his willingness to testify?
A. We were going to review his chart to see what his frame of mind was and why we didn't start -- if his frame of mind at the time was the fact we were most likely adeno, that

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would help him make a decision as to what he could testify to.
Q. Why is my question --
A. The only thing I can think of is that, first -- you've never taken care of critically ill patients, have you? No.
The only thing I can think of is that he -- if this was, indeed, an adenocarcinoma -- the problem was, she was so far gone. That's the problem. I mean, that's the problem. I mean, even if this -- I mean, he couldn't start aggressive chemotherapy because this lady was dying, okay? This lady was in horrible, horrible shape. And she was in horrible pain. And --
Q. But my question, Doctor --
MR. CROSS: Let her finish the answer.
MR. OHLEMEYER: I am.
A. I don't know what you want me to answer. I mean, you're trying to correlate -- you're trying to take two sentences and hook them together and come out with a third one and I can't do that. I think you need to ask

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Dr. Songer this.
Q. But that's my question, is those two sentences are your two sentences, they are hooked together, and I'm asking you to come up with a third one. And if you can't, you can't. That's all I'm asking, Doctor.
A. I can't come up with a third question because these notes are just things I dictated on the phone off the cuff. This is not a legal -- it wasn't a legal document until it disappeared sometime and comes up. You know, I dictate things -- dictate things all the time. But, I mean, you know, you're asking me to fill in blanks. It's not like I went from one to two to three to four here. I mean, I can't answer your question. You'll have to ask Dr. Songer.
Q. Last question, we'll break for lunch.
On the next page it says, "Also of note, the negative mucin staining on the path report of the cancer cells shows maybe there is a faint mucin secreting tumor."
A. Yep.
Q. "It is difficult to say that it is definitively negative."

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A. "Also of note, the negative staining on the path report of the cancer cells shows that maybe there was a faint mucin secreting tumor. It is difficult to say that it is definitely negative. I also talked to Dr. Triplett regarding electromicroscopy. He felt that this would be a waste of time."
Q. I want to ask you about the mucin. Why did you think -- what's the significance of whether the tumor secretes or did not secrete mucin?
A. There are certain types of adenocarcinoma that would secrete mucin.
Q. And there are certain types that would not?
A. Yes.
Q. And is it fair to say, Doctor, that if this was a tumor that did not secrete mucin, it would be less likely to be a primary adenocarcinoma of the lung?
A. I can't tell you that. I'm not a pathologist.
Q. So that's another area of --
A. You need to talk to a pathologist about.
Q. So one other way to critically analyze your opinion would be to determine whether this

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was a mucin-secreting tumor and compare that fact to the collective information.
A. Yes.
MR. OHLEMEYER: Let's take a lunch break.
(A lunch recess was taken.)

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AFTERNOON SESSION

(Deposition Exhibit(s) 23-25 marked for identification.)

BY MR. OHLEMEYER:

Q. Doctor, if you don't understand a question, will you let me know?

A. Yes.

Q. When you perform a mammogram on a patient, do you need to have a consent form signed or do you have to get the patient's consent to do that?

A. Well, you would like to inform them if you're going to take them down to x-ray and do something like that to them, yes.

Q. Are there any risks that you inform them of in connection with the mammogram?

A. There may be some bruising. That's primarily the number one risk I would suspect. I mean the radiation, I'm not a radiologist, but the radiation impact would be minimal.

Q. Is bleeding, collapsed lung, or death a risk of mammography?

A. If it was the person should shut down the

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radiology department.

Q. Okay. Is bleeding and collapsed lung and death a risk of transthoracic needle biopsy?

A. Bleeding, collapsed lung, and death, yes, it would be, yes.

Q. Which procedure is more painful to the patient, a mammogram or a transthoracic needle biopsy?

A. More painful to the patient.

Q. Maybe let me rephrase the question. Which procedure has the potential to be more painful? I take it you try to avoid pain, but of the two procedures, which is relatively more painful?

A. More painful or more risky?

Q. More painful.

A. Depends on the radiology person that's doing it. I mean, you know, some women say a mammography is more painful than a transthoracic biopsy.

Q. Which is more invasive?

A. Transthoracic biopsy.

Q. Doctor, do you have any information, from any source, about Mrs. Wiley and radon exposure?

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A. Do I have any --

Q. Information from whatever source about Mrs. Wiley's potential exposure to radon.

A. Now or then?

Q. Well, let's talk about then, let's talk about now.

A. Yes.

Q. Then?

A. Then, if I did not put it down there, then I probably did not.

Q. Okay. Now do you?

A. Well, from that note on my dictation, I stated, I think it was the 20th of July, I stated that --

Q. June 7th, I think. Let me rephrase the question, might make it easier. Have you acquired any information since June 7th of 1993 from any source about Mrs. Wiley's potential exposure to radon?

A. My understanding, from the information I received, it was low level exposure.

Q. And that was your understanding in June of '93?

A. Well, it depends on when I can find these notes. If I stated it in June 7th versus

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July 20th, you know, I need to look at these to see when I dictated it.

Q. Well, let me rephrase the question then.

MR. CROSS: Well, you've asked it twice, counsel, why don't you let her find her notes and answer it.

MR. OHLEMEYER: Okay, go ahead.

THE WITNESS: Which one is it?

MR. CROSS: It's June 7th.

A. June 7th.

Q. Of '93.

A. Okay. So it says, "Since this patient had no other source of known carcinogen including the fact that radon levels in her house were extremely low or non-existent by history, I feel that there is indeed a direct relationship to her exposure of --"

Q. Let me stop you there. The "by history" is information you obtained from the attorneys?

A. It must have been.

Q. And my question, then, is since that time, since June of 1993, have you acquired any information from any source about Mrs. Wiley's, or the potential -- Mrs. Wiley's potential exposure to radon

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throughout her life?
A. No.
Q. Would you agree with me, Doctor, that radon exposure represents a risk to health of substantial magnitude?
A. There are lung cancers related to radon exposure.
Q. As a practical matter, do you think exposure to radon represents a risk to health of substantial magnitude?
A. Well, substantial is the key word. There are a number of deaths in nonsmokers and smokers due to radon.
Q. Do you know whether --
A. But it's primarily, my understanding is, tobacco exposure is synergistic with radon exposure just like asbestos is synergistic with radon exposure -- I'm sorry, synergistic with tobacco exposure to increase the risk of lung cancer.
Q. I want to make sure you haven't misstated something; when you say tobacco exposure, what you mean is primary smoking.
A. I'm not saying that.
Q. Tell me, quote me, show me where the

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evidence is that tobacco exposure as opposed to primary smoking is suggested to work synergistically with radon exposure to produce lung cancer.
A. I think you need to talk to an epidemiologist or a person from like the Environmental Protection Agency or those type of individuals to get that conclusion and to get the evidence. I'd have to go back through a number of literature to do that.
Q. So as we speak, you're not sure whether the evidence suggests that it's tobacco exposure as opposed to primary smoking that may or may not act synergistically with radon exposure.
A. Well, we know that since environmental tobacco smoke comes out of the end of a cigarette, we know that environmental tobacco smoke has more -- has more toxic chemicals, because the end of the cigarette is smoldering, the temperature of incineration is lower, the particulate material -- I mean, this is my understanding. Again, you could get an

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expert in this area. But we know that environmental tobacco smoke has a -- is -- can be more toxic than primary smoking because of the number of chemicals that come out of the end of that cigarette.
MR. OHLEMEYER: Will you repeat my question, please.
(The requested material was read back by the reporter.)
Q. Let's take this one at a time, Doctor. Are you suggesting to me that there is literature or evidence to suggest that there is a synergistic relationship between radon exposure and exposure to cigarette smoke?
A. You're asking is there literature existing that there's a synergistic exposure to cigarette smoking or cigarette smoke --
Q. Smoke and radon exposure.
A. And radon.
Q. As it relates to the development of lung cancer.
A. Yes, there is.
Q. My question to you is, does that literature suggest that it is exposure to tobacco smoke in general or does the literature suggest or

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indicate that it is the act of primary smoking, act of smoking that demonstrates that relationship?
A. When they say tobacco smoke --
Q. I don't want to interrupt you.
A. I can't put words in a researcher's mouth.
Q. That's my question. Is it your recollection that those words are tobacco smoke or cigarette smoking, the act of smoking?
A. My recollection is tobacco smoke.
Q. So to the extent that evidence or those studies are limited to active smokers, then they -- do you believe -- well, strike that.
To the extent that those studies are limited to active smoking, then your recollection or your assumption is incorrect, isn't it?
A. You're asking is the -- it depends on whether the tobacco smoke -- I mean, I can't tell you, I'm not an epidemiologist, I'm not a research person in this field. What I'm telling you is from what I've read that it talks about radon exposure and tobacco smoke.
Q. And Doctor, in applying what you have read

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to situations such as this, do you think it's important to have a clear or accurate understanding of what it is that's being described in those studies you've read?
A. Yes.
Q. Now, do you know whether the EPA considers exposure to indoor radon as one of the highest carcinogenic risks under its jurisdiction?
A. It's one of the six known carcinogenic agents. EPA has listed six.
Q. Does the EPA rank exposure to indoor radon as one of the highest carcinogen risks under its jurisdiction?
A. By this table, it's the second highest.
Q. What's highest?
A. ETS, environmental tobacco smoke.
Q. To the extent that your assumption is incorrect, might that have an effect on your opinion in this case?
A. My assumption of what is incorrect?
Q. Where and how the EPA ranks exposure to indoor radon as it relates to the risk of developing cancer.
A. You're asking if I -- that would change my

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opinion; is that what you're asking?
Q. Would it affect your opinion. Would it be something you'd have to consider in reevaluating your opinion?
A. If I -- would I use that to change my opinion; is that what you're asking? Would you read the question back, please.
Q. I'll rephrase the question, Doctor. If you are, in fact, incorrect about how the EPA ranks radon as a carcinogenic risk relative to other risks to health, might that information cause you to reevaluate, would that be information you would have to use in reevaluating your opinion in this case?
MR. CROSS: What opinion is that?
MR. OHLEMEYER: About the cause of Mrs. Wiley's cancer.
A. You're asking if I -- if radon is, indeed, a causative agent for lung cancer.
Q. Doctor, I'm asking you whether you agree or disagree with this statement: The EPA ranks exposure to indoor radon as one of the highest carcinogenic risks under its jurisdiction.
You have told me that you believe it

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ranks ETS exposure above radon in terms of risk to health. I'm asking you to assume for me that you're wrong, that they rank radon higher than ETS.
Is that information that you would want to use in reevaluating your opinion in this case and critically analyzing it?
A. I would use that to critically analyze.
Q. Do you know whether the EPA estimates that more or less deaths per year occur as a result of exposure to radon as opposed to exposure to environmental tobacco smoke?
MR. CROSS: Well, counsel, I will object. This was gone into at some length in the morning session, you've asked that question at least twice and she's answered it.
Q. Well, Doctor, can you answer the question for me?
A. Your question is?
Q. Does the EPA consider exposure to radon to produce more or less lung cancer each year in this country than exposure to environmental tobacco smoke?
MR. CROSS: Do you have the

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publication that you're referring from? You're giving her another memory test here.
Q. Doctor, you understand the question.
A. Yes.
Q. And do you understand that you can answer it yes or no or I don't know?
A. My understanding is, from the literature that I have reviewed, that there are around 4,000 deaths, 3- to 4,000 deaths from environmental tobacco smoke.
Q. And how many deaths as a result of lung cancer each year does the EPA attribute to residential exposure to radon?
A. I believe it's around 3- to 4,000.
Q. Do you know whether the carcinogenicity of radon has been demonstrated in experimental animals?
A. I'm not a research -- that has not been a research area that I have enlisted in.
Q. Do you know whether it is possible to identify lung cancers caused by radon exposure as opposed to lung cancers believed to be caused by cigarette smoke or other substances?
A. Now, repeat that question.

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Q. Is it possible to identify lung cancers, to look at the cancer and to determine that it was caused by radon exposure as compared to a lung cancer caused by cigarette smoke or some other substance?
A. I cannot tell you.
Q. Do you know whether at a cellular level lung tumors look the same although they have different causes?
A. Lung tumors from oat cell carcinoma -- being not a pathologist, you would need to talk to a pathologist.
Q. Do you know how one could go about obtaining information about an individual's historical exposure to radon?
A. Well, I suspect most people, you could ask them.
Q. Well, let me stop you there. How would somebody know whether or if they'd been exposed to radon?
A. They would have to take measurements.
Q. How would they do that?
A. I believe there's an instrument that they could buy to look at that.
Q. And what would you do with that information

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in terms of determining whether or if that level of exposure presented a risk to health?
A. Since I'm not a biochemist or an environmental protection person or a specialist in that area, I would suspect that you would need to ask them.
Q. Same thing for asbestos?
A. Well, asbestos, when we have a patient with lung cancer as related to asbestos, there are clinical signs that occur.
Q. Such as?
A. Calcification. First of all, individuals are much more likely to know that they've been exposed to asbestos than otherwise, especially an adult person. And the clinical presentation, the calcifications along the pleura, there's usually cake -- or calcification scalloping along the pleural space.
Q. Can exposure to one asbestos fiber cause lung cancers?
A. One asbestos fiber. You mean somebody inhaled one single asbestos fiber?
Q. Let's assume that one asbestos fiber sloughs

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off an old steam pipe in the hospital and I breathe it.
A. Yes.
Q. Can that one fiber cause lung cancer?
A. I can't tell you that.
Q. How many would I have to breathe?
A. I can't tell you that. It depends on the level of exposure, where it lands.
Q. I know Mr. Young has already thrown his penny in the fountain and wished for that.
MR. YOUNG: I hope the record won't reflect that.
Q. I apologize, Doctor. The lawyers were laughing about something that I thought I had a sense of what they were laughing about. And I don't mean to waste your time.
Had you completed your answer? I mean, the question was how much asbestos does it take --
A. Depends on where it lands, what happens to it. Obviously, it depends on the level of exposure. The intensity of the exposure.
Q. The duration and the intensity and the frequency of an exposure as well as the fate of that exposure in the body?

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A. Again, I'm not a pathologist or epidemiologist.
Q. I'm sorry, I'm thinking out loud, but I want to ask you whether you agree with me. In determining whether a suspect -- we've used the word "carcinogen." Am I correct a carcinogen is typically defined as a substance believed to or suspected of causing cancer in individuals; right?
A. Individuals or --
Q. People.
A. -- people or rats or mice or --
Q. Well, that's the distinction I want to draw; is in animals you can perform experiments to see if exposure to that substance produces the result that you are suspicious for. Right?
A. Yes.
Q. In people, you can study groups of people, try to determine whether they have similar histories of exposure and observe how frequently you find the disease in groups of people; right?
A. Normally what they do is they look at a group of people, groups of people, decide

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how much cigarettes, heart disease or whatever, and study those.
Q. But my question really is, is with respect to people, is it fair to say that the duration, the intensity, the frequency of exposure to a suspected carcinogen will play a role in determining whether that person develops cancer as a result of that exposure?
A. And I would suspect their genetic makeup, yes.
Q. And even add to that the fate, how the body deals with that exposure; right?
A. Yes.
Q. Because the body has certain defense mechanisms it can bring to bear on exposure to certain things; right?
A. If those body mechanisms work.
Q. In fact --
A. Well --
Q. -- there are some carcinogens that we are -- "we" being you and I and others -- are exposed to in different aspects of our everyday life; right?
A. Air, water, food, what?

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Q. Well, are there carcinogens in the food we eat?
A. Pesticides, possibly.
Q. Are there carcinogens in the air we breathe?
A. Depends on where you breathe. I try to protect my air.
Q. Well, when you're driving down the highway on a busy street or a busy road, is it possible, or is it likely there are carcinogens in the area as a result of the combustion of fossil fuel?
A. Anything is possible. But, again, it has to do with how much you inhale, a lot of different things.
Q. Duration, intensity, frequency, genetic makeup, and the fate of the substance once it's ingested or inhaled; right?
A. You really would need to talk to an epidemiologist or a biochemist regarding that and look at the numbers. You know, what you're doing is you're pulling things out way back here and pulling it in.
Q. Well, here's my question, Doctor. You believe environmental tobacco smoke to be a carcinogen.

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A. It contains carcinogenic agents. Thousands of carcinogenic agents.
Q. Is that your testimony, that there are thousands of carcinogenic agents in environmental tobacco smoke?
A. Depends on the amount of tobacco smoke that's in a room.
Q. Well, Doctor, how many substances have been identified in environmental tobacco smoke that are suspected of producing cancer in experiments?
A. My understanding, there's approximately 50 in one -- in the tobacco smoke that comes off of an end of a cigarette.
Q. And how many of those substances -- I may have asked you this, I don't mean to repeat, but am I correct there is no single substance in that group that is found only in environmental tobacco smoke.
A. There is no single substance in that group. I can't tell you that.
Q. So is it fair to say that some of the things that you believe to be present in environmental tobacco smoke that you believe to be carcinogens may be substances that

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individuals are exposed to in other aspects of their life separate and apart from any potential exposure to environmental tobacco smoke?
A. What you're asking is -- what you're asking is, is there -- does environmental tobacco smoke have a group of carcinogenic agents in it that may be in other areas. Or better yet, what you're asking, I suspect, is the density of carcinogenic agents in this one substance is equal to other areas.
Q. Doctor, the question is very simple. You've told me that you believe there are carcinogens in environmental tobacco smoke.
A. That has been proven, yes.
Q. And when you say carcinogens, you mean substances that have been demonstrated in other experiments, not involving environmental tobacco smoke, to produce cancer in animals.
A. I can't tell you that.
Q. Well, my question is, are any of those substances unique to environmental tobacco smoke? Are any of the substances that you believe to be carcinogens that are present

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in environmental tobacco smoke found only in environmental tobacco smoke or could I find any of those substances in either air or food or water or other --
A. You would need to get a scientist that his field of study is this and ask him those questions.
Q. So you can't tell me whether there are substances in environmental tobacco smoke that are believed to be carcinogens that somebody, including Mrs. Wiley, might have been exposed to at some other point in her life or as a result of some other exposure in her life.
A. What you need to do is get a scientist that that field of research is that, those chemicals and environmental tobacco smoke, and ask him that question.
Q. So the answer to my question is you can't tell me the answer to that question.
A. I suggest that you get a scientist that has to do with that research and ask him because I don't want to tell you the wrong thing.
Q. Do you know whether anyone has ever measured or taken any measurements in the Marion

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Veterans Administration Medical Center?
A. I can't tell you that for sure, no.
Q. Have you ever been there?
A. Yes.
Q. Were you ever there when Mrs. Wiley worked there?
A. No. I don't think so. You mean in the ward itself or on the campus or what?
Q. Well, let's talk about your understanding of where Mrs. Wiley worked. Were you ever present in those buildings during the years she worked there?
A. No.
Q. Have you ever taken or have you ever seen any measurements that anyone else has taken of the air quality in that ward?
A. No.
Q. Do you have any information beyond what Mrs. Wiley or Mr. Wiley may have told you or the attorneys for Mr. and Mrs. Wiley may have told you about the level, the frequency, duration, or the intensity of environmental tobacco smoke Mrs. Wiley may have encountered at that Veterans Administration Medical Center?

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A. All I have is from what -- from those sources.
Q. How did you determine that Mrs. Wiley was exposed to enough environmental tobacco smoke to cause or to have caused her lung cancer?
A. How did I determine that Mrs. Wiley was exposed --
Q. To enough --
A. -- to environmental tobacco smoke --
Q. To have caused her lung cancer.
A. From her history she stated and Mr. Wiley had stated that she had been exposed to this on a daily basis. My understanding is there was -- they told me there was a total haze in the area. That's what his word was -- words were. And that when she came home she was -- smelled quite heavily of it. And that she was concerned that she was being exposed to this.
Q. When did he tell you that?
A. Well, from my history that I have, I probably -- I recollect that probably from -- from her -- from him. He probably told me during the time she was in the

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hospital. The other part of that was when I was looking back, in 1993, looking back at the case and clarifying data on the case.
Q. And by that time, Mr. Wiley had already filed a claim against the Veterans Administration for compensation relating to his wife's exposure to environmental tobacco smoke at that facility.
A. I don't know when he filed that.
Q. Well, let me hand you --
MR. OHLEMEYER: Let's mark this as the next in order.
(Deposition Exhibit(s) 26 marked for identification.)
(Discussion off the record.)
Q. Doctor, this is Exhibit 26. Is that your signature there at the bottom? I know it's hard to read.
A. Yes.
Q. Date 4/28/92?
A. Yes.
Q. This is a form, apparently, that you were asked to fill out in connection with Mr. Wiley's claim against the Veterans Administration?

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MR. CROSS: Excuse me, counsel, could I see that?
MR. OHLEMEYER: I'm sorry.
A. I don't know if --
MR. CROSS: Just a minute, Doctor.
Q. My question, Dr. Turner, is that by April of 1992 somebody had asked you to state an opinion as to whether Mrs. Wiley's death was due to her employment. Isn't that right?
A. Yes.
Q. Okay. So prior to 1993 -- well, so my question then is, is if the discussion you had with Mr. Wiley occurred in 1993, that you just told me about, it would have occurred after he made his claim against the Veterans Administration.
A. I would suspect so.
Q. All right.
A. Unless -- you know, I don't recall talking with him other than during the time that she was -- I have not seen him since the day she died. And so...
Q. But you've been provided with information through the lawyers about Mr. Wiley's description or the description of others

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about the Veterans Administration facility, haven't you?
A. Yes.
Q. And that occurred before or after April of '92?
A. I can't tell you. I can't tell you for sure.
Q. Okay.
A. I don't really recall discussing much of this with anybody other than around the time of, you know, June, July of '93.
Q. All right. Dr. Turner, do you know whether there is any type of immunohistic chemical test or any other biologic or genetic test that can be or has been performed to establish whether Mrs. Wiley had a primary lung cancer or whether her cancer was associated with exposure to certain substances?
A. Your question is has it been done?
Q. Are you aware of any immunohistic chemical test or any other biologic or chemical test that has been done or could be done to determine whether Mrs. Wiley had a primary carcinoma of the lung and whether or if she

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had been exposed to certain substances that are suspected of causing primary carcinoma of the lung?
MR. CROSS: Well, objection, that's a compound question. That is two totally distinct subjects there.
Q. Doctor, do you understand the question?
A. The question is, was there anything done: right?
Q. Well, or are you --
A. Or can they be?
Q. Are you aware of any that have been done. Let's take it one at a time. Are you aware of any immunohistic test or biological test that has been performed to establish whether Mrs. Wiley had a primary carcinoma of the lung?
MR. CROSS: Thank you.
A. Not that I'm aware of.
Q. Are you aware of any immunohistic chemical test or biological test that could be performed to establish whether she had a primary carcinoma of the lung?
A. Histochemical. Well, given the -- histochemical for adenocarcinoma?

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Q. Primary carcinoma of the lung.
A. Primary carcinoma of the lung. My understanding is there's no need to do that. But I'm not a pathologist. Maybe there's something new out that I don't know about. But adenocarcinoma of the lung would be diagnosed at the time of the transthoracic biopsy and the autopsy.
Q. Are you aware of any immunohistic chemical test or other biological or genetic test that could be performed to establish whether Mrs. Wiley had a primary carcinoma of the lung?
A. You need to ask a pathologist.
Q. Have you been told or made aware of or become aware of any such tests that have been done in this case?
A. My understanding, when we talked about it way back in July, there was some literature that could have -- that would have suggested that to be done.
Q. And do you know whether that kind of test has been done?
A. I can't be certain.
Q. And can you tell me what literature that is?

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A. Not in front of me, no.
Q. Can you tell me what type of test it is?
A. Some type -- I think it's a marker for some of the chemicals in secondhand smoke.
Q. So as we sit here today, you don't know whether that test has been done?
A. I can't be certain, no.
Q. Have you talked with the lawyers about doing that kind of test?
A. Back in July I did. July of '93 or whenever it was when I was -- when I was asked to look at the studies, when I was asked to look at this case, and look at the literature out there, that was in some of the literature that I looked at.
Q. And to your knowledge, they've never come back to you and said, hey, we did a test and here are the results?
A. They have not told me for sure that that has been done.
Q. Have they told you for almost sure or unsure that's been done? I mean, I don't want to quibble with you, but you've been very careful with your words. Have they told you --

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A. I'm trying to be very careful with my words all along.
Q. I know, that's why I asked. You said they haven't told you for sure it's been done. Have they told you they're thinking about it or considering it?
A. My understanding is they were considering it. Now, whether they did it or not for sure, I can't tell you.
Q. Would that kind of information make you more certain of your opinion or less certain of your opinion?
A. If that was done, it would help me make a decision, yes.
Q. Would you want to know the results of that kind of test regardless of what they indicated?
A. Yes.
Q. Would the results of such a test be helpful in critically analyzing your opinion?
A. Depends on the percentages of the specificity. It depends on, you know, the percentages that it would be positive.
Q. Specificity being how specific that type of test is to the substances at issue.

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A. Yes. Again, a biochemist with research in that area would be much -- would be an optimal witness.
Q. Take a look at your death summary again. Exhibit 12. I can hand you a copy.
A. I got it right here.
Q. You see at the bottom of the page where it says, "Cytology revealed questionable squamous cell, therefore, a transthoracic biopsy was performed by Dr. Huss. This revealed an adenocarcinoma."
A. Yes.
Q. Can you show me where in the records the support is for that statement? I mean where did you -- from where did you -- what's the basis for your statement that that transthoracic biopsy revealed an adenocarcinoma?
A. A transthoracic autopsy revealed, has to do with Dr. Baldwin's note.
Q. The one where Dr. Baldwin said the two of them thought it might be adeno, one thought it might be a squamous cell?
A. Yes.
Q. So the pathology note does not say the

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transthoracic biopsy reveals an adenocarcinoma, does it?
A. Let me look at that specific piece of paper and I will tell you. Okay. It says, "Fine needle aspiration, lung." So tissue received, fine needle aspiration. It says "fine needle aspiration"; that would be consistent with a transthoracic biopsy. Since I didn't do a fine needle aspiration, Dr. Sprunger didn't do a fine needle aspiration, only I had forceps.
Q. I understand that. But that transthoracic biopsy, the pathologist who did the report on -- who rendered the pathological diagnosis didn't render it quite so succinctly as you did, did they? They don't say this reveals an adenocarcinoma, do they?
A. It says, "Fine needle aspiration, lung, right upper lobe: Adenocarcinoma." There's no adverbs in there, but it says adenocarcinoma right there.
Q. And it also says that Dr. Sandquist and Dr. Baldwin favor that diagnosis, whereas Dr. Brown favors a diagnosis of poorly differentiated carcinoma.

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A. Yes.
Q. That was the discrepancy we discussed earlier that somebody was going to check into and clarify for you.
A. Yes.
Q. And that, to your knowledge, was never checked into and clarified.
A. Well, I don't think that's right. I mean, he did not put a note in the chart, but the point is, is that he did not make an addendum to this, either. And so if someone does not make an addendum, his diagnosis is adenocarcinoma, or he would have said we came back, reviewed the slides again, additional pathologist looked at the slides and this is our diagnosis. The fact that this is left in the chart, there's no other additional ones, makes me think that Dr. Baldwin, since he put his name down there, that he says this is adenocarcinoma.
Q. Dr. Turner, has anyone in your family ever suffered from an illness that you attribute to exposure to tobacco smoke, either directly or indirectly?
A. Yes.

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Q. Who?
A. My father.
Q. And was your father a cigarette smoker?
A. Yes.
Q. And I take it -- is your father alive?
A. No. He's died.
Q. When did he die?
A. 1990.
Q. And to what do you attribute his death?
A. Tobacco.
Q. What was the cause of his death?
A. End stage pulmonary disease.
Q. Secondary to what?
A. Tobacco smoking.
Q. Did he have lung cancer?
A. We did not do an autopsy.
Q. Are there other things that can cause end stage pulmonary disease besides tobacco?
A. End stage pulmonary disease with severe emphysema and chronic bronchitis.
Q. That's my question, Doctor. Are there other risk factors for those diseases?
A. Extremely, extremely, extremely low. Heavy, I mean, heavy -- not really. Not to that extent, no.

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Q. How long was your father sick before he passed away?
A. He was probably ill for probably 15, 16, 17, 18 years.
Q. And what month in 1990 did he die?
A. November.
Q. It's fair to say, then, that your involvement with Mrs. Wiley occurred about six months after your father's death?
A. About eight months, yes. But you have to understand I've been involved with a lot of patients in the eight months that my dad died.
Q. Dr. Turner, do you know anything besides what is recorded in the material that we've marked already as exhibits about Mrs. Wiley's work schedule, her hours, her shifts?
A. All I know is that, I think from someplace I read she had become a supervisor and that's all I know.
Q. Do you know anything about the types of patients she cared for at the VA?
A. No.
Q. Do you know anything about how many patients

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were in the ward she worked or was responsible for at the VA?
A. No.
Q. Do you know anything about how many of those patients smoked cigarettes?
A. No.
Q. Do you know anything about how many of the nurses or other health care professionals she worked with smoked cigarettes?
A. No.
Q. Do you know anything about the smoking policy at the VA?
A. Then or now?
Q. Then.
A. No.
Q. Do you know anything about other chemicals Mrs. Wiley may have come in contact with as a result of her work as a nurse?
A. No.
Q. Have you ever looked at her employment records?
A. No.
Q. Have you ever talked with any of her co-workers?
A. No.

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Q. Do you have a file on this case that you keep at home?
A. No.
Q. Let me ask you some questions about -- first let me show you what I've marked as Exhibit 23.
MR. OHLEMEYER: Counsel, I'm sorry, I only have one copy of that.
Q. And let me hand you 24 with it. They kind of go together.
MR. OHLEMEYER: I do have a copy of 24, you guys. You can have that.
Q. Doctor, let me hand you 24. 24 is a medical authorization. You understand what that is; right?
A. Yes.
Q. You're not free to divulge or disclose medical records on your patients without authorization of the patient.
A. Right.
Q. And typically in a case like this where there's litigation involved, the lawyers or the administrator of the estate have to sign that and that allows you to produce medical records.

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A. Yes.
Q. There's a note in the top right-hand corner of that authorization, will you read that for me?
A. Says. "Dr. Turner - I sent copies of these back to Mr. Meredith stating she was not seen in our office. Sylvia."
Q. Sylvia is your secretary?
A. Well, one of them.
Q. Apparently what happened in February of '94, somebody came to your office with an authorization --
A. Uh-huh.
Q. -- wanted medical records and a long list of other things, actually, with respect to Mrs. Wiley.
A. Yes.
Q. And your secretary told them that you didn't see Mrs. Wiley in your office, only at the hospital: therefore, all the records would be at Ball Memorial.
A. If that's what she said. All I know is that --
Q. Well, let me hand you 23.
A. Okay.

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Q. That's apparently the note that she wrote.
A. "Did not see Mrs. Wiley in our office - only at the hospital. (Therefore, all records would be at Ball Memorial.)"
Q. Right.
A. Yes.
Q. And that's consistent with your understanding of how things worked over here at --
A. Well, the problem is, our chart disappeared. And we kept looking for the chart, we couldn't find it.
Q. When did it disappear?
A. Sometime around the time of '93, '94. All I know is that we were -- we continued to look for that and we could not find it.
Q. Did Sylvia tell Mr. Meredith that the chart had disappeared and you were looking for it and couldn't find it in February of '94?
A. I don't know if she did or not.
Q. Well, what she wrote to Mr. Meredith there is that --
A. She probably looked for the chart in our files, it was not there. And therefore, she said there was no current file there. So

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she was being truthful that there was no current file and she didn't probably think that we had any file.
Q. She didn't tell him that she thought the records were lost?
A. She didn't know that, I don't think, at that time. In February of '94 I don't think she knew.
Q. Well, in February of '94, all we know is that when somebody came here with an authorization to collect records on a patient that you knew was involved in litigation, your secretary told them we don't have any of those records because she was treated at the hospital, not in our office; right?
MR. CROSS: Well, I'll object to this.
MR. OHLEMEYER: I'll withdraw the question. I'll move on.
Q. The point is, Doctor --
A. Let me tell you the files were not there. Now, we looked, and they were not there. And we felt that they had disappeared.
Q. But my question to you, though, is that's

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not what you told Mr. Meredith or your secretary told Mr. Meredith when he came with the authorization to look for the records.
A. Well, since I did not -- I mean, I did not write this chart, I did not write this note, Sylvia did.
Q. So she's the one we'd have to ask about that.
A. Yes.
Q. We might do that.
So where would, for example, Exhibit 3 have been kept in connection with Mrs. Wiley's records? Would it have been kept at the hospital? Would it have been kept at the office?
A. It would have been kept in the chart.
Q. And the chart, presumably, there should have been a chart in your office.
A. Should have been a chart out there where all the other charts were.
Q. So that record wouldn't be at Ball Memorial.
A. Exhibit 3?
Q. Yes.
A. No.

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Q. Is it true, Dr. Turner, that you did not see Mrs. Wiley in your office?
A. That is true.
Q. It's true you only saw her at the hospital?
A. Yes.
Q. Is it true that in patients you don't see -- is it true that in a patient who is not seen at your office but only seen at the hospital, all records about that patient would be at Ball Memorial?
A. We would have gotten copies of her chart -- of her x-rays and most likely they would have -- that's all we would have gotten is a copy of the discharge summary that would have been sent to us, since I dictated it, and a copy of some of the x-rays.
It depends on who orders the x-rays. I may not have gotten all the copies. If Sprunger ordered an x-ray, it may have gone to his office and not ours. Not everybody on this list, five people, get copies. Whoever ordered the x-rays and whose name is at the top, unless there's a carbon copy to, those people don't get x-rays. Don't get copies.

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So I can't tell you how much of that chart we had and how much -- all I know is we could not find it. And it disappeared.
Q. Well, but my point is, for all you know, the only thing Mr. Meredith was told was what's described here in Exhibit 23. He wasn't told it was lost or disappeared or you couldn't find it.
A. All I can tell you is what I know. She might not have even known, other than looking, it wasn't there.
Q. Where do you keep your progress notes that are dictated about the patient post death?
A. Post death.
Q. Do you have a file somewhere that says "Mildred Wiley progress notes"?
A. It should have been kept in the file.
Q. Do you have that file?
A. You have it. I don't have the original file. All we have is what we found on microfilm.
Q. Or what the lawyers sent you.
A. Or what the lawyers sent me, whatever they got.
Q. Let me hand you what I've marked as Exhibit

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25. This is another one of your dictations dated May 25, 1993.
A. Yes.
MR. WAGNER: What exhibit number is that?
MR. OHLEMEYER: This is Exhibit 25, right.
(Discussion off the record.)
Q. So this was dictated the day after Exhibit, the first page of Exhibit -- well, the day after Exhibit 3; right?
A. Yes.
Q. And this describes that discussion you and Dr. Songer had about the patient's chart; right?
A. Reviewed the patient's chart, discussed it at length, yes.
Q. Where did you obtain that chart? Was that chart here in the office?
A. I don't know where this came from.
Q. No, the chart that you're talking about in this memorandum, in this progress note --
A. Reviewed the patient's chart.
Q. -- where would you have obtained that chart?
A. Most likely, I would suspect, from the

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hospital.
Q. And during your discussion, the question arose as to whether or not you were dealing with a breast cancer versus a lung cancer; right?
A. Breast cancer versus lung cancer, yes.
Q. And Dr. Songer and you both called this Dr. Dana-Farber in Boston?
A. I can't remember if I did or not. He may have been the only one that called him. I can't remember. I do not recall calling this gentleman, unless it says so in this, if it says so in this memorandum.
Q. Then you talked with Dr. Kocoshis again about the autopsy; right?
A. About the slides. Filtration of pancreatic tissue; again the question arises of whether this -- yes.
Q. And the question arises because the appearance of infiltrates on pancreatic tissue taken at autopsy is suggestive of a primary pancreatic tumor, isn't it?
A. No. It says I discussed the case with Dr. Tom Kocoshis again about the slides; apparently there was some infiltration of

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pancreatic tissue.
"Again the question arises of whether it may be pancreatic. However, on gross section and at the autopsy report there was no evidence of ductal obstruction or other primary in the pancreas itself."
Q. So one way we could critically analyze your opinion or Dr. Kocoshis' opinion would be to have a pathologist look at those slides to determine whether there was ductal obstruction in the pancreas; right?
A. Or other sources of primary cancer of the pancreas, which is what we talked about before.
Q. So ductal obstruction in the pancreas would be a sign of or suggestive of --
A. I can't tell you that.
Q. Dr. Kocoshis apparently told you that, though; right?
A. No. On gross, there was no evidence of ductal obstruction or other primary in the pancreas itself.
Q. So my question to you, Dr. Turner, what would the significance of evidence of ductal obstruction be?

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A. You would need to talk to Dr. Kocoshis or a pathologist about that.
Q. What would the significance of infiltration of the pancreatic tissue be if it was observed on those slides?
A. Well, again, a pathologist would be much better to discuss that.
Q. So in May of '93, you and Dr. Songer were discussing with a pathologist whether there was pathological evidence to suggest a primary cancer at a site other than the lung.
A. You're asking, were we looking at it to see if there was any other source of a primary cancer; is that correct?
Q. Yes. That's what's going on here; right?
A. Yes, that's what I said, yes.
Q. And then you wanted to look back at all her mammograms --
A. Yes.
Q. -- because there was still some question as to whether or if you were dealing with a primary breast cancer.
A. Yes.
Q. And then you talk with the lawyers again.

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A. Well, let's see here.
Q. Last paragraph.
A. About smoking exposure, she apparently had an open door policy to her office, yes.
Q. And that is the -- they are the source of that information. Mr. Tom Young, Mr. Riley discussed with you smoking exposure and gave you information, provided to them, supposedly, by Mrs. Wiley's husband about her exposure to smoke.
A. Yes.
Q. Did you ever make any effort to contact nurses who had been on that ward to help you verify whether or if Mrs. Wiley was exposed to environmental tobacco smoke and determine whether they would be witnesses for this?
A. No.
Q. Do you know if anyone else has?
A. Perhaps the lawyers have. I don't know.
MR. OHLEMEYER: Let me mark this next in order.
(Deposition Exhibit(s) 27-28 marked for identification.)
Q. Doctor, this is a copy of a fax apparently sent to you from the Young Riley & Dudley

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law office on 10/21/97; right?
A. I don't know if I sent it to them or they sent it to me.
Q. See at the top there where it says from?
A. I guess so.
Q. They sent it to you; right?
A. Yes.
Q. You see --
A. This was at my request. Okay?
Q. Do they typically, do you -- in the past four years, have you typically requested of them and have they typically complied with your request about sending stuff to them?
A. They haven't sent me hardly anything. The reason why this was requested was because I was at this Indiana State Medical Association meeting and I was talking to one of the physicians there that's on the Tobacco Task Force and he noted that this study had just come out that day or he got it on the Internet. I requested it from our library, our library had not received it and, therefore, I wanted to be prepared because you had told me I needed to be prepared. So I wanted to try to be as

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prepared as possible and that's why I requested this.
Q. Well, you and I, Dr. Turner, had never spoken to each other prior to October 21 of 1997; right?
A. If that's the day that we had our first deposition, no.
Q. You see the little scribbles there to the right-hand side of the citation bar?
A. Yes.
Q. Are those your scribbles or their scribbles?
A. Those are mine.
Q. You kind of drew that, it looks like a cigarette; right?
A. Where?
Q. Like the end of a cigarette?
A. No.
Q. See right here?
A. Those are doodles.
Q. Okay, that's just a doodle, all right. That's my question. Is it a doodle or is it a cigarette?
A. It's a doodle. For Pete's sake.
Q. Whose underlining is it?
A. Mine.

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Q. Okay. Let me ask you a couple of questions, Doctor --
A. Geez.
Q. -- about -- it is fair to say that lung cancer is not really a single disease but it's actually different histological diseases and subgroups of diseases. I mean, lung cancer isn't really precise, is it?
A. Lung cancer --
Q. Let me rephrase the question. I mean is it important to determine what type of lung cancer you're dealing with in order to determine treatment of a patient suspected of having lung cancer?
A. Repeat the question again.
Q. Let me back up to where I started. Is lung cancer a single disease or is it a combination of different diseases or disease processes?
A. Lung cancer, well, there's -- there may be one or two cell types involved. Most likely it's one cell type, but it's hard to say. Sometimes there's two or three. So diseases, you're talking about --
Q. Well, let me, I guess what I'm getting at --

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A. It's a very vague question.
Q. I know, but that's kind of the point of the question. To describe something as a car doesn't necessarily tell you whether it's a Ford or a Chevy or a BMW.
To describe something as lung cancer doesn't tell you whether it's adenocarcinoma, squamous cell carcinoma, small cell carcinoma, large cell carcinoma; right?
A. Yes.
Q. And there are different types of lung cancers.
A. There are different types of lung cancers.
Q. And that's one of the reasons you send a specimen to a pathologist, to help identify that cell type for you.
A. Yes.
Q. And the risk factors for the development of lung cancer can vary among cell types; right?
A. The risk factors may vary among the cell types, yes.
Q. Some cell types are less strongly associated with cigarette smoking than others?

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A. Yes.
Q. There are some cell types that are thought not to be associated with cigarette smoking.
A. I can't tell you that for sure.
Q. What about bronchioalveolar carcinoma? It's really a subtype, I guess, of a cell type?
A. Yes. I can't tell you for sure. My understanding is that it can occur in smokers.
Q. Does the cell type give you any indication about where the cancer began?
A. Does the cell type tell you where it began.
Q. Does it -- well, does it allow you -- does it give you any information about where the tumor began?
A. Well, squamous cell is most likely seen in the airway.
Q. Can I stop you there. That's because it's thought to arise in the squamous cells in the airway; right?
A. In the epithelial cells.
Q. In the epithelial cells. And there are other types of cancer that are thought to occur in other types of stem cells, that only occur in certain types of organs in

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certain parts of the body; right?
A. Yes.
Q. So, for example, a small cell carcinoma, the diagnosis of small cell carcinoma helps you determine a range of places where that cancer could have occurred and then the literature and the epidemiology gives you some percentages of where it's most likely to occur.
A. Well, my understanding is small cell carcinoma is primarily from the lung.
Q. That's -- I don't mean -- but that's kind of what I'm trying to get at. That's an example of a diagnosis that helps you pinpoint a source; right?
A. Yes.
Q. And is it fair to say that as opposed to small cell or squamous cell carcinoma that adenocarcinomas can arise in a larger number of organs in the body?
A. Adenocarcinoma can arise in other areas of the body, yes.
Q. Is adenocarcinoma the most frequently occurring tumor in North America?
A. Okay, adenocarcinoma of the other organs --

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Q. Adenocarcinoma in general. Is that the most frequently occurring --
A. Not being an oncologist or pathologist --
Q. Is it the most frequently occurring lung tumor in North America?
A. My understanding is adeno has surpassed squamous cell. But, again, a pathologist or oncologist would be able to tell you.
Q. Can all lung cancer cell types occur in nonsmokers?
A. My understanding is, in my references, squamous and oat cell, I have not seen them in nonsmokers, but a pathologist or an oncologist would be able to tell you.
Q. And is it fair to say that, although sometimes you're limited by what you can do, that, all things being equal, a diagnosis of cancer is a pathological diagnosis, you prefer to have a pathologist help make the diagnosis?
A. A diagnosis of cancer -- I'm not a pathologist. You would need -- I'm not going to diagnose a cancer on you without a piece of tissue and a pathologist, trained pathologist looking at that.

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Q. That's my question.
A. You're talking about diagnosis versus suspicion, too.
Q. Impression versus diagnosis, suspicion versus diagnosis, I understand that, Doctor. And I appreciate, one of the challenges you face as a doctor is sometimes you have to deal with impressions, not diagnosis, but that's my question; the diagnosis of cancer is a pathological diagnosis.
A. A diagnosis, if you put something down as a diagnosis, you would like that to be verified by a pathologist with tissue as best we can.
Q. Yes. Do you understand the word or phrase "multifactorial" as it relates to lung cancer?
A. Multifactorial means that cancer may occur from a number of factors.
Q. And are there a number of factors associated with the development of lung cancer?
A. Are there a number of factors that are associated with the development of lung cancer.
Q. Number of risk factors, I guess I meant.

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A. Number of risk factors. There can be.
Q. And one of them is cigarette smoking?
A. One of them is cigarette smoking.
Q. One of them is air pollution. Well, let's say environmental factors.
A. There may be environmental factors. Including environmental tobacco smoke.
Q. Air pollution and radon?
A. Radon, air pollution. It depends on the degree of exposure and where you live.
Q. Occupational factors are associated with an increased risk of developing lung cancer?
A. Occupational factors, depends on what you're exposed to.
Q. Asbestos, heavy metals, things like that.
A. Depends what you're exposed to.
Q. Is diet a risk factor for the development of lung cancer?
A. You're asking diet or pesticides or what?
Q. Well, I mean, is there evidence to suggest that certain diets make one more or less likely to develop lung cancer?
A. I can't tell you that. Let me go back to one of your previous questions and clarify. You asked the question, and I can't --

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THE WITNESS: Can we back up? He was talking about oat cell and squamous cell, whether --
Q. I'll ask -- I mean, Doctor, I'll let -- I mean, I was just trying to use it as an example. I guess my question was, are certain -- well, I don't know. You tell me. What is it you don't understand? I mean, what did you want me to ask?
A. I want to answer your question.
Q. What question is it?
A. Well, the question arose --
Q. You answer it and then I'll ask it.
A. The question arose is whether oat cell and squamous cell -- I can't even remember the question. My answer was I have not seen them in nonsmokers. But the point is, is that non-primary smokers, but secondhand smoke, we have had diagnoses that may -- I mean, I can't tell you that secondhand smoke may not have caused some of those cancers.
Q. What you're saying, I think, is this: That you have observed squamous cell carcinoma or small cell carcinoma in nonsmokers and you, at this point, are either suspicious of or

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can't rule out the possibility that those tumors were caused in your opinion by exposure to environmental tobacco smoke.
A. What I'm telling you is that in the ones I have experienced, the ones I have diagnosed, helped diagnose, with squamous cell or oat cell carcinoma, virtually all of those have been smokers. Primary smokers. How much secondary smoke increased their risk because of exposure to secondary smoke, that's what I'm saying.
Q. Well, what's a bigger risk to health, Doctor, primary smoking or exposure to environmental tobacco smoke?
A. It depends on the level of the exposure.
Q. Do you think heavy exposure to environmental tobacco smoke is more or less a risk to health than smoking a half a pack of cigarettes a day?
A. An epidemiologist would be able to tell you better but it depends on the level of exposure to that secondhand smoke.
Q. Let's call it a heavy exposure.
A. What's a heavy exposure?
Q. Doctor, my next question is -- well, I don't

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know, you tell me.
A. You have to ask the question. I want to answer it truthfully. What's heavy exposure?
Q. When I use the words "heavy exposure," you don't know what I mean?
A. It depends on -- heavy exposure, heavy exposure is exposure to a number of cigarettes, secondhand smoke cigarettes.
Q. Well, is a heavy exposure to environmental tobacco smoke more or less of a risk to health than smoking a half a pack of cigarettes a day?
A. What do you mean by heavy exposure?
Q. So you need more information than I've given you to answer the question.
A. I need to know what the exposure is.
Q. All right. Thank you, Doctor.
My next question is, Are you familiar with medical literature that associates certain duties with an increased or a decreased risk for developing lung cancer?
A. I can't tell you whether it's lung cancer or not. I do think that because of the pesticides that are in animal fats and

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pesticides on vegetables that I'm not sure that they increase your risk of lung cancer but they may increase your risk of other cancers.
Q. Are you familiar with any studies of nonsmoking women to determine whether their diet increased or decreased their likelihood of developing lung cancer?
A. No. I may have read literature but it's been a long time ago and I don't want to misquote it.
Q. Do you know if family medical history is associated with increased risk of developing lung cancer?
A. Family history.
Q. Family medical history.
A. I can't -- a geneticist may be able to be helpful to you. There are certain cancers that can increase, whether it's lung cancer or not is not clear. I mean, I can't tell you.
Q. So you don't know whether there's an increased familial risk for lung cancer in individuals who are nonsmokers who have relatives with lung cancer?

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A. No, I do not.
Q. Do you think viruses can cause lung cancer?
A. I'm not a research person. I mean, what kind of viruses are you talking about?
Q. Well, there's been some talk about a virus found in polio vaccines and its relationship to certain types of cancer.
A. What's the incidence?
Q. Well, that's my question.
A. I have not read that literature.
Q. Okay. But as a theoretical medical person, do you believe there is a case to be made, an argument to be made for a viral etiology for cancer?
A. I'm not a research scientist in that area. I have not read that specific --
Q. Do you think that every cancer is caused by something external to the body or do you think there are cancers that occur as a result of, you know --
MR. FURR: Metabolism.
Q. -- endogenous events?
A. Endogenous events, such as --
Q. Genetic defect, metabolism?
A. Metabolism to what effect?

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Q. That's my question, Doctor. Does every cancer have to have an external cause?
A. Metabolism is a broad area.
Q. It's a broad question. Do you think all cancers require an external event?
A. I mean, a research scientist in this area, an oncologist would be much more likely to answer that question for you.
Q. Do you think -- you are familiar with literature that suggests stress is related to an increased risk of developing lung cancer.
A. A stress could be -- well, if -- if it -- I can't answer that question.
Q. Do you think there are some cancers, including lung cancers, that just occur without any apparent cause? An idiopathic.
A. Certain lung cancers can occur -- I can't answer that question, either.
Q. And I appreciate what you're telling me. You're telling me that you're not saying that that's wrong, or I'm incorrect, you're just saying you don't have background, education, familiarity to --
A. I think you need to talk to an oncologist

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that has researched in that area or that would be familiar with that literature. I have not reviewed that literature. I don't want to misspeak.
Q. How well understood are the biological mechanisms by which cells in the lung become cancerous?
A. I believe there are mutations that can occur.
Q. Do scientists understand how they occur in such a way they can prevent them from happening?
A. Well, again, a biochemist would be helpful in that situation. I'm sure he would be much more enlightened than I would be.
Q. What's the survival rate for lung cancer patients today as compared to what it was say 10 or 15 or 20 years ago?
A. I believe -- I have it here. It's -- I've looked this up. I believe it's about 14 percent. That used to be about 9 percent at nine years. Now it's about 14 percent.
Q. Would you characterize that as a big improvement, small improvement, or moderate improvement?

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A. Dismal.
Q. I mean, here's kind of a theoretical question for you. You know, in light of all the technological advances and therapeutic modalities and equipment and brains being put to this, why do you think the survival rate's improved so little over the years?
A. Because patients are still poisoning themselves with carcinogenic agents and unless we can ask -- get them to quit poisoning themselves, our hands are tied.
Q. By "poison" I take it you would include cigarette smoking and environmental tobacco smoke.
A. Yes.
Q. But not limit your definition of poisons to that; right?
A. The majority -- I mean the majority of patients that I see with lung cancer are related to those, primarily from primary tobacco smoke.
Q. Do you think if there was no cigarette smoking there would be no lung cancer?
A. I think our percentages would drop precipitously.

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Q. How do you know whether or if there are other things in the environment that might cause lung cancer at a similar rate?
A. Because we've not proven that that has happened. I mean, there is no other environmental toxin that people put in their body that we are aware of that causes such an incredible -- incredible number of illnesses.
Q. I take it you would agree with me, Doctor, that if there were no cigarette smoking there would probably still be lung cancer, although, as you've suggested, at a lower rate in this country.
A. 90 percent of lung cancers are related to tobacco abuse. So if you drop out tobacco, and secondhand smoke, we would not have as many lung cancers, and really illnesses, heart disease, the different types of cancers that, you know, are correlated with tobacco smoke.
MR. OHLEMEYER: Take a short break, is that okay, five minutes?
For the record, we ought to reflect that we've marked the Notice of Continued

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Deposition of Dr. Turner as Exhibit 26.
(A recess was taken.)
Q. Doctor, if you don't understand a question, will you let me know?
A. Yes.
Q. We've marked as Exhibit 22 the notes that you produced today.
A. Yes.
Q. Can you tell me when and how you prepared these notes?
A. I prepared them over the last probably week.
Q. And how did you go about doing it?
A. I reviewed literature from a number of sources.
Q. Can you tell me, you don't cite --
A. I can get the sources if you want. Want me to go get them?
Q. At some point I want a list.
A. Primarily I wanted good review articles, several good reviews, but Richard Bone, he just died of renal cell, he was the editor, and I did an updated text and this is where those are from.
Q. It's a textbook, Bone, B-O-N-E?
A. No, it's a series of updated literature on

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critical care.
Q. Did all of the information on these notes come from that source?
A. Except back in 1992, EPA, and those came from tobacco papers by Glantz, Stan Glantz.
Q. Got you. And this is -- tell me why you put this together. This reference together.
A. I was trying to kind of summarize things in my own mind.
Q. Are these things that you had researched prior to undertaking this exercise?
A. Researched.
Q. I mean, had you done this kind of research before and just not written it down or --
A. I have given a number of lectures on tobacco and I have written this down on a number of occasions. But these, this collection of notes are for this occasion.
Q. "This occasion" being the deposition?
A. Yes.
Q. Doctor, am I correct that in your July 20, 1993 letter that we've marked as Exhibit --, help me out. What's the exhibit number?
A. I don't know, it's not on here. Wait a minute. July -- 21.

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Q. Exhibit 21?
A. Yes.
Q. You cite a reference to Blot and Fraumeni, F-R-A-U-M-E-N-I. I think it's on the fourth page. Fourth page?
A. Yes.
Q. That was an article that you obviously had reviewed in advance of preparing your July 20, 1993 letter.
A. I guess, yes.
Q. You wouldn't have -- you couldn't have cited it if you weren't aware of it prior to the time you prepared the letter; right?
A. Right. Yes.
Q. Now, am I correct, Doctor, that you cite it for the proposition and support for the proposition that involuntary smoking can cause cancer in nonsmokers?
A. Do you have the article there?
Q. Well, look at -- here's what I'm saying. You see on page 3 of your July 20th report --
A. Yes.
Q. -- says at the bottom, "In summary then, in this report, by the Surgeon General of the

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United States, it did state that involuntary smoking can cause lung cancer in nonsmokers"?
A. Yes.
Q. Then you go on to cite a report by Kuller; right?
A. "Strong suspicion, even in 1986, that environmental tobacco smoke was related to lung cancer."
Q. Then you go on to site the OSHA Bulletin 54.
A. Yes.
Q. Then you go on to cite the study, you cite Wald, Blot, and -- you cite Wald, et al., and Blot and Fraumeni for the proposition that studies have been done that support the proposition that involuntary smoking can cause cancer in nonsmokers; right?
A. If that's what I stated.
Q. That's what it says there, isn't it?
A. Yes.
Q. Now, the studies at that time, in 1993, the studies that associated an increase in risk of lung cancer among nonsmoking women involved women who were exposed to cigarette smoke primarily through spousal exposures;

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right?
A. Yes.
Q. They weren't studies of women being exposed to --
A. I don't know about all the studies. The studies that were cited in 19-, I believe 1981, published in 1981, there were two studies published, and I don't have those in front of me, that had to do -- and I'm not sure both of them had to do with spousal exposure, but they were studies I believe for lung cancer in nonsmoking women.
Q. But even up to the point where the EPA looked at this question in their risk assessment, the vast majority of studies that they relied upon were studies of spousal exposure.
A. I can't tell you spousal.
Q. All we have to do is go back and look at the studies.
A. You need to look at the studies.
Q. All right. The two studies you talked about in 1981, I think we referred previously to as Hirayama and Trichopoulos --
A. Yes.

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Q. -- were criticized at the time they were published because they had not evaluated exposure to environmental tobacco smoke outside the home; right?
A. I can't tell you that. That they were criticized. Who criticized them?
Q. Well, are you aware of any criticism in the literature of those studies at the time they were published for any reason?
A. I'm not aware of any.
Q. Wouldn't surprise you if there was some criticism of a study like that. I mean, is criticism something that --
A. Why would they be criticizing? I don't quite understand.
Q. Well, when people study things and publish the results of their studies --
A. Yes.
Q. -- isn't there some sort of critical discourse that usually ensues?
A. There can be.
Q. Especially if it's something that is new or previously unreported?
A. It can be.
Q. And one of the things people can criticize

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are the conclusions researchers have drawn from their data.
A. There can be critical assessment.
Q. They can criticize the materials and methods they've used to reach their conclusions?
A. Yes.
Q. In fact, those are all the kinds of things that you should look at critically in evaluating the reliability of research, aren't they?
A. Yes, you have to look at the whole body of research, articles. And whether other individuals have come out with similar results.
Q. Is it fair to say that the Hirayama and Trichopoulos findings were greeted with some skepticism in part about some questions that were raised about the methods that were used and the sufficiency of the exposure to environmental tobacco smoke that nonsmokers might have experienced?
A. It looks like you're looking at an article. Can I read that?
Q. I'm just asking, Doctor, whether you agree with me or not that the Trichopoulos and

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Hirayama findings were greeted with some skepticism when they were published in part because of the questions raised with regards to the methods they used.
A. I can't tell you that.
Q. Would it surprise you?
A. Would it surprise me if they were greeted with some skepticism?
Q. Yes.
A. Would it surprise me if they were greeted with some skepticism. I mean, if things did not make sense, if things were not done correctly, then possibly there was some skepticism.
Q. Now, as of 1993, as of July 1993, there had been studies conducted of groups of nonsmokers who were exposed to cigarette smoke as a result of living with a smoker that did not demonstrate an increased risk for the development of lung cancer; isn't that right?
A. I believe that there was some studies out there. But again, it had to do with their methods.
Q. What do you mean?

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A. And I believe the problem is, is that had to do with the fact that individuals would not admit to the level of smoking exposure.
Q. Let's back up for a minute, Doctor. Am I correct that, as of July of 1993, there had been studies published involving nonsmokers living with smokers in which an increased risk for the development of lung cancer was not found or demonstrated?
A. I cannot tell you which study they were. I cannot tell you how many studies there were, and whether these are adequate studies.
Q. What criteria do you determine whether a study is adequate or not?
A. If a study is adequate, it appears to me that it has other individuals that are doing the same research, other individuals are coming to the same conclusions in the medical literature. And epidemiologic literature.
Q. Do you know a researcher by the name of Ernest Winger? Are you familiar with Dr. Winger's work?
A. I may have read some of his articles. It's difficult to tell you that.

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Q. Do you know what relationship Dr. Winger has to the study of smoking and health?
A. No.
Q. Have you ever heard of Dr. Winger in connection with the relationship between smoking and health?
A. Again, I may have read some of his literature but I do not recall his -- that he was the author of any of that. There may have or may have not. Unless you put the article in front of me I can't tell.
Q. Let me use an example for you. When people talk about the polio vaccine, they think of Jonas Salk; right?
A. Right.
Q. When you think of research associating smoking and risk to health, who do you think of?
A. Probably Stan Glantz. As well as some others.
Q. And who else?
A. Wilbur Pace. There was a number of articles. I mean, I don't -- you have the stuff in front of you. It's kind of like I can go back and get the articles and look at

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the authors if you like.
Q. Can you give me some idea of who the major researchers were in the 1950s who associated cigarette smoking with risk to health?
A. I do not have that information.
Q. Can you tell me who the major researchers were who published studies relating smoking to risk to health prior to the time of the 1964 Surgeon General's Report?
A. I do not have that in front of me.
Q. If you wanted to find that information, where would you look for it?
A. Probably look at the U.S. Surgeon General's Report and look at the bibliography and go back and do a review of the literature from perhaps 1950 on.
Q. Have you done that?
A. Have I done that? I may have done that at one time but I don't have it in front of me.
Q. Have you done it in connection with forming any of the opinions you've reached in this case?
A. Yes.
Q. What have you done?
A. Well, I've went through, again, the U.S.

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Surgeon General's Report. I've went through all the literature that I could find that appeared to be current, read that. Looked at some of the bibliographies from that literature and side references. I've done -- I mean, I've tried to do as extensive research as possible, looking at the literature.
Q. Tell me, Doctor, whether you agree or disagree with this statement: As of July 1993, the cumulative epidemiologic evidence suggests that smokers married to smokers -- nonsmokers married to smokers -- suggest that nonsmokers married to smokers experienced a small to moderate increased risk of lung cancer?
A. Small to moderate risk.
Q. Increased risk of lung cancer.
A. My understanding, it's higher. What do you consider small to moderate percentages?
Q. Well, my question to you, Doctor, as of July of 1993, would you agree that the epidemiologic evidence developed to date suggests that nonsmokers married to smokers experienced a small to moderate increased

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risk of lung cancer?
A. My understanding, from looking at some of the literature that I reviewed, it was approximately 30 percent higher risk. Now, depends on what you mean by small to moderate.
Q. Well, tell me what you mean. Do you think a 30 percent increase is a small to moderate increased risk to developing lung cancer?
A. If I had one chance of carrying on an activity and I had a 30 percent chance of getting a lethal disease from carrying on that activity, I would not do it. I think that is a significant risk.
Q. Are there other things --
A. Like putting a bullet into a three-chamber gun and spin the chamber and see if it hits you.
Q. Well, Doctor, I can appreciate that's your assessment of it. But let me ask you this: What else do you do in your life that exposes you to a risk of developing cancer greater than 1.3?
A. I can't think of anything either. Nothing.
Q. Do you think that exposure to

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electromagnetic fields increases your risk of developing lung cancer by more or less than 30 percent?
A. I would suspect it would be less.
Q. But you don't know?
A. I'm not -- I'm not aware that I've been exposed extensively to electromagnetic fields, unless I don't know about things, about where I'm being exposed to at.
Q. Do you know whether being exposed to radon in your home increases your risk of developing lung cancer more or less than 30 percent?
A. Well, I don't live in a home. I live in an apartment. Do I know that -- what's your question?
Q. Well, my question to you, Doctor, is: Do you believe that you encounter any risk to your health in your day-to-day routine that increases your risk of developing lung cancer by a factor of 1.3 or more?
A. Not that I'm aware of.
Q. So is it your testimony that a 30 percent increase in risk, a relative risk of 1.3, is or is not a small to moderate increased risk

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of lung cancer?
A. I think it's a significant risk.
Q. Do you think it's -- could you characterize it -- would you characterize it as a small to moderate increased risk of lung cancer?
A. Well, to me, significant is higher than moderate.
Q. Well, do you know how epidemiologists use the phrase?
A. I'm not an epidemiologist.
Q. Do you know whether an epidemiologist would consider a relative risk of 1.3 to be a small, moderate, or significant risk?
A. You would have to ask an epidemiologist.
Q. My question to you is, is do you agree or disagree, that as of July 1993, the cumulative epidemiological evidence suggested that nonsmokers married to smokers experienced a small to moderate increased risk to --
(Brief interruption.)
Q. Doctor, do you agree or disagree with me that as of July 1993 the epidemiologists who had studied the relationship between --
A. If that epidemiologist stated that, that's

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his opinion.
Q. Well, my question to you, Doctor --
A. I don't know what you --
Q. -- do you agree or disagree with it?
MR. CROSS: Asked and answered at least ten times. Objection.
A. I would say if I had a risk of 1.3 and I knew that there was a 30 percent higher risk of developing a terminal disease, I would not take that risk. To me that's a significant risk. I'm telling you from my point of view and from my opinion.
Would you like to have a 30 percent risk of -- if you knew that you were going to do an activity and you have a 30 percent risk of dying, would you do that activity?
Q. Doctor, would a 30 percent risk of dying double the chances that you were going to die as a result of that activity?
A. 30 percent risk of dying double the chance that I would die.
Q. Would a 30 percent risk double your chances of dying as a result of that activity?
A. I think you're mixing words. I don't understand your question.

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Q. Well, my question to you, Doctor, is, explain to me what you think a 30 percent risk to your health means. Does it make it twice as likely or a third as likely that something is going to happen to you?
A. I would say that it's probably a 30 percent risk higher than normal that I would die of that activity.
Q. And so that makes it less than twice as likely that that would happen.
A. Yes.
Q. It makes it less than half as likely that it would happen.
A. 30 percent higher risk of dying from that whatever, getting that disease process.
Q. And whether that increase in risk is small, moderate, significant is something, from an epidemiological perspective, you would let the epidemiologist answer.
A. Yes.
Q. And that's what they do for a living, isn't it?
A. Yes.
Q. And that's --
A. Unless it happens to be having -- I mean, if

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your family -- if your child had a 30 percent risk of developing some type of tumor or cancer that may be lethal, that will be lethal, would you want them to be exposed to that?
Q. Doctor, let's put it this way: You can't use that epidemiology to determine what caused a disease in any particular person, can you?
A. They said that there was a 30 percent risk of developing lung cancer or some type of disease from environmental tobacco smoke. Isn't that what that said?
Q. Doctor, did you understand the question I asked you?
A. Go ahead.
Q. Can you use epidemiology, can you use an epidemiologically-derived estimate of relative risk to determine what caused cancer in a specific individual?
A. It may help you decide what the chances are that that, the etiology that you've selected, occurred.
Q. And in a nonsmoking woman who has adenocarcinoma of the lung --

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A. Yes.
Q. -- who claims to have been exposed to environmental tobacco smoke --
A. Yes.
Q. -- the chances are more likely than not, based on the epidemiology, that something other than environmental tobacco smoke caused her disease.
A. No, I do not believe that you can say that. From my point of view, from a clinical perspective, if I'm taking a history, I would not say that. No.
Q. From an epidemiological perspective, Doctor.
A. You'll have to talk to an epidemiologist.
Q. So you can't tell me whether the epidemiology suggests that it is more likely than not -- well, strike that.
You can't tell me whether the epidemiology indicates that a woman like Mrs. Wiley is twice as likely to have developed lung cancer.
A. From my understanding, the studies that I have read, and the studies I can recall right now, her chance is 30 percent or more.
Q. Which is less than twice as likely.

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A. It's not two. It's less than twice as likely.
Q. So a relative risk of 1.3 --
A. 30 percent.
Q. A risk of 30 percent increase in risk does not tell you, based on the epidemiology, that a disease in a specific individual was more likely than not caused by exposure to that risk factor.
A. You're asking if that 30 percent risk, that there's a 30 percent chance, is that what you're asking?
Q. Here's what I'm asking you, Doctor. Listen real carefully.
A. I'm trying. Really, I am. But you keep re- --
Q. Let's take it a step at a time. You have a patient who's a nonsmoker --
A. Yes.
Q. -- who claims to have been exposed to environmental tobacco smoke; right?
A. Not claims. She was.
Q. Doctor, I'm not talking about Mrs. Wiley, okay?
A. Okay, that's fine.

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Q. Can you help me for a minute? Divorce yourself from the facts of the case. Let's talk about general principles, okay?
A. Okay.
Q. And you smile because I take it it's difficult for you to do that, isn't it?
A. No. I'm smiling because I'm trying very hard to answer your question.
Q. Let's talk about data, let's talk about things that you can teach a class, things that you can prove, things that you can say for certain --
A. Yes.
Q. -- without judgment, without opinion.
If we have an individual who didn't smoke, who has lung cancer, who claims to have been exposed to environmental tobacco smoke, isn't it correct that the epidemiology suggests that it is more likely than not something other than environmental tobacco smoke that caused that individual's cancer?
MR. CROSS: Objection, asked and answered.
A. What else would there be?

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Q. Doctor, we don't -- that's the point. If you don't know what else there would be, the epidemiology suggests to you, doesn't it, that it is more likely than not something other than environmental tobacco smoke caused that person's cancer?
A. I don't think you can say that. The numbers say that exposure to environmental tobacco smoke -- if I was exposed to environmental tobacco smoke and I came down with a lung cancer and I had -- and I had exposure, my risk of that being the cause of my lung cancer is about 30 percent.
Q. So the chances that that exposure caused your lung cancer are about 30 percent. Right?
A. Yes, one in three, yes.
Q. So the chances are that that exposure didn't cause your lung cancer is 70 percent. Right?
A. You'd have to ask an epidemiologist.
Q. All right. Now, Doctor --
A. I don't want to -- I don't want to misspeak. I mean, an epidemiologist, they have the ability to look at numbers and...

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Q. As of July 1993, was there any uncertainty about the causal nature of the relationship between environmental tobacco smoke and lung cancer in light of the limitations that are involved in assessing exposure to environmental tobacco smoke?

MR. CROSS: Would you read that question back.

MR. OHLEMEYER: Let me rephrase it.

MR. CROSS: Just read that one back first.

MR. OHLEMEYER: Well, have it your way, but I'm not sure there's --

(The requested material was read back by the reporter.)

A. The literature that was out there by July of '93 stated that individuals were developing lung cancer on the basis of environmental tobacco smoke.

Q. And did the literature that was out there, Doctor, in July of 1993 indicate that there was some uncertainty about whether that relationship, the fact that nonsmokers were developing lung cancer, was a causal one because of the limitations that are inherent

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in determining how much or whether people had been exposed to environmental tobacco smoke?

A. In some of the literature that was reviewed, including the first two authors that you talked about in 1991 -- 1981, their literature I believe, and some of the review articles that I looked at, what they looked at is the probabilities, and the fact that we knew that primary tobacco smoke caused lung cancer. Okay?

I mean, I can't divorce -- I mean, you can't divorce the fact -- this is what they wrote in some of their articles. You can't divorce the fact, you can't take environmental tobacco smoke and say, well, this is a new type of being, it has nothing to do with primary smoke.

Q. Can I stop you right there?

A. Yes.

Q. But it is, in fact, a different chemical substance from primary smoke.

A. No, it isn't.

Q. That's your opinion?

A. No.

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Q. Is it your opinion that environmental tobacco smoke is or is not a distinct chemical substance from primary cigarette smoke?

A. The same chemicals that are in primary smoke, many of the same chemicals that are in primary smoke are in environmental tobacco smoke, or where else would it come from?

Q. Do you know what happens to the chemistry of tobacco smoke when it leaves the end of a burning cigarette?

A. Precipitates into the air. I mean, it's into the air.

Q. Do you know anything else about what happens to it?

A. Well, I do know that some of the literature -- and you've got the notes there -- that when a -- when the chemicals are inhaled by a primary smoker, the temperature of that cigarette is about 900 degrees. At the end of a smoldering cigarette, it's about 400 degrees. I do know that environmental tobacco smoke is -- can be more toxic than primary smoke because

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the chemicals that are not incinerated, some of the chemicals that a primary smoker inhales are incinerated and some of the ones that are coming out of the end of a cigarette are not and, therefore, are more toxic.

Q. Do you know -- well, you know that because you've read it and you believe it.

A. Yes.

Q. But, Doctor, my question to you is, do you know what happens to the chemistry of that smoke? Do you know if those substances change chemical nature, change shape, get diluted?

A. I think you need to -- I mean, I could tell you what I read, I could surmise, but I'm not a scientist in that area.

Q. So you don't have any background, education, or expertise in the chemistry of environmental tobacco smoke as it relates to mainstream smoke.

A. I have no background -- what did you say?

Q. Education or expertise.

A. Well, I have read a number of articles.

Q. But it's not an area in which you believe

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yourself to be qualified by reason of background, education, or experience to explain it to us.
A. Well, compared to --
Q. Is that right?
A. -- to the individuals, other physicians -- I probably know more about environmental tobacco smoke than other individuals.
Q. But my question to you is, Doctor, do you feel qualified by reason of your background, education, or experience to state with reasonable certainty what happens to the chemicals in tobacco smoke when they are either emitted from the side of the end of a burning cigarette or come out the proximal end of a cigarette when it's smoked?
A. I can tell you that there is partial degradation, there may not be -- I can tell you that those are inhaled by people that are standing there inhaling them. I can tell you that your risk of cancer, if you inhale those particles and those cancer -- those chemicals is increased. I can tell you that.
Q. Can you tell me how many of those chemicals

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are present inside a building apart from any contribution that might be made by environmental tobacco smoke?
A. Are there -- you asked that before. Are there any chemicals --
Q. Can you tell me, Doctor --
A. Yes.
Q. -- how many chemicals that you believe to be generated or created through other than the process of environmental tobacco smoke that might otherwise be present in the air in a building separate and apart from smoking?
A. I think you need to get a chemist and environmentalist probably from the EPA that had studied that area.
Q. Can you tell me how the level of those chemicals in environmental tobacco smoke compare to the level of similar or identical chemicals that might be found in air separate and apart from the contribution of tobacco smoke or environmental tobacco smoke?
A. You just asked that question.
MR. CROSS: You have asked that question and you've asked several questions

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that are so far beyond her realm of expertise, she's told you she doesn't know the answer to these questions.
MR. OHLEMEYER: That's fair. With your representation, Mr. Cross, I'll move on.
Q. Doctor, my question to you, my question to you, Doctor, is do you believe or would you agree with me that as of July of 1993, the epidemiologists and others who were studying the issue of environmental tobacco smoke and its relationship to disease had concluded there was some uncertainty about the causal nature of that association in part due to the limitations that are involved in assessing exposure to environmental tobacco smoke on a historical basis?
MR. CROSS: Objection, asked and answered.
A. I answered that before.
Q. And the answer is yes, you agree with that.
A. My answer --
MR. CROSS: Objection, restating her testimony. That's not what she said.
A. Yes, you can review the testimony that I

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gave before. You keep asking the same question. I'm not going to change my testimony.
Q. Can you answer this one yes, no, or I don't know: As of July 1993 there was uncertainty about the causal nature of the association between environmental tobacco smoke and disease in view of limitations involved in assessing exposure to environmental tobacco smoke?
MR. CROSS: Same question, same objection.
A. I mean, I answered the question before.
Q. And is the answer yes, no, or I don't know?
A. You're asking was there a direct cause, was there a degree of certainty that environmental smoke, environmental tobacco smoke caused cancer. Is that what you're asking?
Q. I'm asking you, Doctor, very simply, was there --
A. Can I read it? Can I read it off your paper? It's such a long question, I'm trying to make sure I get it.
Q. It's really very simple. As of July of

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1993 -- are you with me so far?
A. Yes.
Q. -- are you aware of any uncertainty expressed by people studying this subject about the causal nature of the association between environmental tobacco smoke and disease? For any reason.
A. There was a number of literature -- there's a number of -- a lot of literature out there, a number of articles that were published, in fact, I believe there was like 30 additional studies between 1982 and 1994, you know, that stated that they felt that there was a causal relationship between environmental tobacco smoke and lung cancer. Is that --
Q. And there were also authors and researchers who believed there was some uncertainty about that relationship, weren't there?
A. Well, it depends on who the authors were, who paid them.
Q. Well, how about try this one on, Doctor. How about Dr. William Blot and Joseph Fraumeni?
A. Is that that article you just read?

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Q. It's an article you cited in your July 20th letter; right?
A. I would have to read the article so I did not misspeak. Do you have the article there?
Q. Doctor, my question to you is: If that article contains this statement, would you agree with me it's not contained in your July 20, 1993 letter?
MR. CROSS: I'll object to the form of your question. You're asking her to speculate on something she says she does not have committed to memory and then you're asking her whether she would agree with you, to agree with your speculation.
Q. Let me ask a better question. Do you believe -- did you believe, Doctor, in 1993, that there was any uncertainty about the causal nature of the association between environmental tobacco smoke and its relationship to lung cancer?
A. Did I believe at that time --
Q. That there was any uncertainty about the causal relationship between, causal nature of the association between environmental

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tobacco smoke and lung cancer?
A. Let me answer this in this way: Given the fact that we cannot divorce -- and you're asking my opinion. I'm not a research scientist. I did not write these articles. But in my opinion, you cannot divorce environmental tobacco smoke from primary smoke. Since we know that primary smoke causes lung cancer, it is not very difficult to surmise that environmental tobacco smoke caused the same, since the same pollutants are there, the same cancer-causing material's there.
Q. Well, let me start right there. If it's that simple, why did it take somebody until 1981 to publish that opinion?
A. I believe a lot of that is related to -- it's just like AIDS. Why did it take how many millions of people or how many hundreds of thousands of people dying before they realized what was going on? Has to do with what is out there, what is allowed to be out there from the tobacco industry.
Q. Well, what do you need to know from the tobacco industry to buy a pack of

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cigarettes, determine what comes off the end when they're burned, analyze it chemically, and determine whether or if those are the same chemicals that are in mainstream smoke?
A. What do you need to know from the tobacco industry --
Q. I mean, anybody, using your -- using your thought process here, Doctor, if cigarette smoke is bad, then environmental tobacco smoke must be bad. Why couldn't the surgeon general in 1964 have proclaimed, if cigarette smoke causes cancer, environmental tobacco smoke is going to cause cancer?
A. I think he was going, if I remember -- I don't have the author's stuff in front of me, I don't have the papers in front of me, but I believe in that 1964 there was some conjecture that there was a danger due to environmental tobacco smoke. I would have to look at it to be certain. But there was some conjecture in that initial report.
Q. So any scientist, researcher, public health official could have taken that conjecture and used it as an inspiration, as it were, or as the motivation to do that kind of

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research as early as 1964.
MR. CROSS: Objection.
Q. Right?
MR. CROSS: That question asks her to widely speculate to something far afield from the relevance of this case or her association with it.
Q. What would have prevented somebody, Doctor, from taking that conjecture and doing something with it?
MR. CROSS: Same objection.
A. My understanding, there was some scientists that were doing the work, but it has to do with money, has to do with how much outside influences there are. I mean, one of the reasons AIDS is so -- AIDS research right now is so prevalent is because there's a lot of emotion involved, a lot of outside pressures.
I mean, it has to do with the population at the time, how much is known, what can be allowed to be known, how much money is involved, how many people are dying.
Q. Do you know how much money cigarette

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companies have contributed to organizations to conduct research into areas of smoking and health?
A. What companies have they contributed to?
Q. Well, do you know that? Do you know whether --
A. I mean, they have their own, like the Tobacco Research Council that's supposedly research funded, but my understanding is, from reading, that they do research and sometimes they bury it, sometimes they don't. I don't know.
Q. Well, you read that in Dr. Glantz's book; right?
A. Yes.
Q. You don't know whether Dr. Glantz is right or wrong about that, do you?
A. Why would he be wrong? Why would he lie?
Q. Because maybe he doesn't have all the information, Doctor. Maybe people who have asked him his opinion haven't given him a sufficient amount of information to make a judgment. Is that possible?
A. Maybe the people that what now?
Q. Let me rephrase the question, Doctor. Do

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you know whether the tobacco -- whether any tobacco company has ever given any money to the American Medical Association to study the relationship between smoking and disease?
A. They may have. I can't tell you for certain yes or no.
Q. Do you know whether tobacco companies have given money to universities to study the relationship between smoking and cancer?
A. They may have.
Q. Do you think that's good or bad?
A. Depends on what is done with the research.
Q. Well, do you think --
A. What kind of stipulations there are, what happens to the research after it's developed.
Q. If they give money to organizations to conduct research and put no stipulations on what those organizations can do with it, you wouldn't find that unreasonable, would you?
A. If they put no stipulations on the research, and the researchers are true to form, they're not just being paid to conduct research to make things look good, I would

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have to look at the research.
Q. And you haven't done that.
A. I've looked at some of it, yes.
Q. Through Dr. Glantz's book?
A. No. No.
Q. What have you looked at?
A. There's a research in Canada, there's a Canadian college that you, the tobacco research people, paid and they published a book that was sent to a number of public libraries talking about that there was no definite evidence of cancer related to tobacco.
Q. Doctor, let me ask you this one more time, and it's really a simple question. In July of 1993 --
A. Yes.
Q. -- when you wrote your opinions -- and by the way, the opinions that you've expressed in Exhibit 21, I take it you stand by those opinions; right? I mean, it's not something you've created and sworn to, but it certainly contains your best, most accurate, reasonably certain opinions, does it not?
A. The opinions I put in the July 20th was

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related to what I had read, the people that I had quoted, and that's the way it stands, yes.
Q. But, I mean, would you have sworn to these opinions in July of 1993?
A. Would I have sworn. If I had the articles in front of me, and these are directly related to the articles and that's what I got this information from, I would have to.
Q. Where did you get those articles that you cited in connection with this letter?
A. Well, I spoke before, I most likely did a lot of research and read the U.S. Surgeon General's Report, looked at bibliography from that, talked -- you know, had some information sent from a number of cites.
Q. Including the lawyers?
A. No. No. They didn't give me any information to go in this.
Q. Is there any way for us to go back and figure out what changes you made to this letter from the June 7th draft that resulted from any discussions you had with the lawyers?
A. What changes. Well --

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Q. As you look at this, or think about it, can you say to yourself the lawyers, you know --
A. The only thing I can tell you is, they specifically stated you need to be a little bit more specific, you need to be a little bit more in-depth. That's it.
Q. And you recall whether they told you you need to delete anything?
A. No.
Q. And as we sit here today, again, you have no recollection as to why any particular sentence or thought was deleted.
A. Not that I'm aware of. Unless you have something that I don't have.
Q. Doctor, so here's my question: In July of 1993, did you, Dr. Nicki Turner, believe there was any uncertainty about the causal relationship between environmental tobacco smoke and lung cancer?
A. Given what I knew, what I had read, what the preponderance of evidence was from the literature, what I had seen, I felt that there was a causal relationship, since you cannot divorce environmental tobacco smoke from primary smoke.

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Q. So in your mind there was no uncertainty about the causal nature of the association between environmental tobacco smoke and lung cancer.
A. I just spoke what I said. I have to state that, in my mind, from what I had read, the literature I had read, what I knew about the substances, the fact that primary smoke causes lung cancer, that the chemicals are the same or similar, that there's chemicals -- that thousands of chemicals come off the end of a burning cigarette, you have to make -- and only a lunatic would not think that there was, you know -- I mean, if you saw -- I mean, looking at the literature, looking at what I knew, what I had read, that's what I felt in July of '93.
Q. As of July 1993, only a lunatic would conclude that there was any uncertainty about the causal nature of the association between environmental tobacco smoke and lung cancer?
A. What I'm telling you is --
Q. That's the question I want you to answer.
MR. CROSS: Let her answer the

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question.
A. I've answered it four times.
Q. No, Doctor, please listen carefully to the question. As of July 1993, is it your opinion that only a lunatic would have believed there was some uncertainty about the causal nature of the association between environmental tobacco smoke and lung cancer?
A. What I'm telling you, in my opinion, the causal relationship, in my opinion, was there.
Q. I understand what your opinion is. I understand how you arrive at your opinion. What I want you to tell me, Doctor, is whether you believe that as of July 1993 only a lunatic would have believed that there was any uncertainty about the causal nature of the relationship between environmental tobacco smoke and lung cancer.
A. So you're essentially telling me that I'm calling anybody else that disagrees with that a lunatic. Is that what you're saying?
Q. They're your words, Doctor, not mine.
A. Then let's delete that. I'm saying --
MR. CROSS: Doctor, answer the

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question.
Q. Go ahead.
A. You're harassing people; that's what you're doing.
Q. Doctor, I think the record will reflect that I'm not harassing you, but --
A. Yes, you are. You're asking the question in eight different types of modes.
Q. And, you know, Doctor, quite frankly, the record might also reflect and reasonable minds might believe you haven't answered them, but you and I shouldn't have to debate that right now.
My question to you is, using your words, do you believe that as of July 1993 only a lunatic would have believed there was any uncertainty about the causal relationship between environmental tobacco smoke and lung cancer?
MR. CROSS: Dr. Turner, answer the question again for the gentleman, please.
A. I'm telling you that from my experience on July 20th, when I wrote this note, when I wrote this dictation, I'm telling you that from the research that's out there -- and

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I'm not saying somebody is a lunatic or not, okay? I'm just saying from the literature that's out there, from the people that have researched it, okay? There's a number, like I said, there was over 30 articles written between '82 and '94: additional studies that were written.
From the two studies that were published in 1981, January of I believe '81, and you quoted those, the fact that you cannot divorce primary smoke from environmental tobacco smoke, the fact that the same chemicals are there, the fact that there are over 50 -- there's a number of carcinogenic agents, and we know that, in environmental tobacco smoke as well as primary smoke. We know that. We know that lung cancer is related to primary smoke. Then the causal relationship. And I would have to agree with the studies. That's what I've stated.
MR. CROSS: Can we take a break?
THE WITNESS: I would like to take a break.
MR. OHLEMEYER: Sure.

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(A recess was taken.)
Q. Doctor, if you don't understand the question, will you let me know?
A. Yes.
Q. How would you characterize -- what level -- how would you characterize a level of exposure to environmental tobacco smoke at the VA Medical Center that you would not associate as a cause of Mrs. Wiley's cancer?
A. Well, according to the literature, I believe it's from the EPA, there's no safe exposure level. So therefore, I mean, that's essentially -- I mean, you're asking me --
Q. The EPA makes an assumption, do they not, that there is no safe level of exposure to any carcinogen; right?
A. There's no safe exposure level to environmental tobacco smoke.
Q. No, my question to you, Doctor, is, does the EPA make an assumption, in assessing risk to health, that there is no safe level of exposure to any carcinogens?
A. I cannot tell you that, you'll have to ask them.
Q. Let me ask you to assume it's true. Then is

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it -- well, let me rephrase the question.
If Mrs. Wiley was only exposed to half as much environmental tobacco smoke as you have assumed she was exposed to, do you believe it was still enough to have caused her cancer?
A. If she was exposed to just half --
Q. Half as much as you have assumed.
A. Depends. Since there is no safe exposure to environmental tobacco smoke, I cannot tell you what level would be required or would be safe. I mean, obviously, there's no safe exposure level.
Q. That's my question. Your opinion is, is that there is no level of exposure to environmental tobacco smoke below which you would not attribute Mrs. Wiley's lung cancer to her exposure to environmental tobacco smoke.
A. You're asking me -- restate the question again.
Q. My question, you have assumed that Mrs. Wiley was exposed to environmental tobacco smoke at work for 12 years.
A. Well, later on we find it was 18 years.

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Q. Well, you found that out because the lawyers told you that.
A. No, we found that out because Philip Wiley told us that.
Q. Told the lawyers who told you; right?
A. Philip Wiley either told me directly during the time that she was on the ward or from the lawyers, yes, through the lawyers.
Q. Let me ask you this: Would your opinion change if Mrs. Wiley was only exposed to environmental tobacco smoke for 12 years?
A. Depends on the level of exposure.
Q. What about if she was only exposed for ten years?
A. Depends on the level of exposure.
Q. Okay. What is it about -- what level of exposure over that time period would be necessary to produce the cancer? You keep telling me it depends on the level of exposure --
A. Yes.
Q. -- so I want you to tell me at what level of exposure would you not be able to --
A. Depends on how many cigarettes -- I mean, a specialist, an EPA specialist that looked at

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the level that she was exposed to -- obviously, there's -- I mean, from the EPA and from the literature that's out there there is no safe exposure. You're asking me to answer a question --
Q. Well, that's my question, Doctor. Is it your opinion that any exposure to environmental tobacco smoke at the VA Medical Center caused Mrs. Wiley's disease or is it your opinion that there is a level of exposure below which you would not be prepared to say or to opine was a cause of her disease?
MR. CROSS: Which of those two questions do you want her to answer?
MR. OHLEMEYER: I want her to answer both of them.
MR. CROSS: Why don't you ask them one at a time then.
Q. Well, Doctor, you keep telling me, these are your words, "it depends on the level of exposure."
A. Yes.
Q. My question to you is what depends on the level of exposure?

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A. Her risk of lung cancer.
Q. My question to you is, is there a level of exposure to environmental tobacco smoke at the VA that could be demonstrated below which you wouldn't be able to say was a cause of her disease? Or are you telling me that any exposure to environmental tobacco smoke at the VA caused her disease?
A. I'm saying that at the level that she explained to me that she was exposed to, that's how I made the diagnosis of adenocarcinoma secondary to the environmental tobacco smoke.
Q. Well, and all that we have in terms of the information Mrs. Wiley provided to you is contained in your admission note.
A. Well, it's contained in the entire record.
Q. So it's in -- prior to her death, we ought to be able to find information in the medical records that describes Mrs. Wiley's descriptions to you of her exposure to smoke at work.
A. She was exposed -- she was exposed, she stated, 12 years. Later on we found out it was 18 years.

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Q. But Doctor, later on was after you had already concluded that Mrs. Wiley's cancer was caused by exposure to environmental tobacco smoke; right?
A. No. Not -- I can't tell you that for certain because her family -- and I told you this before. I mean, we had a long discussion regarding what was going on. And one of the reasons why -- in fact, one of the reasons why I felt very, very, very strongly that there was a causal relationship between her adenocarcinoma and her lung cancer is because of the smoking exposure, secondhand smoke exposure, as well as to the presentation.
Q. Okay. But all you know about that exposure is what they told you.
A. Yes.
Q. You don't know how many cigarettes were smoked at the VA while she worked there?
A. They told me there was a haze.
Q. You don't know how many cigarettes were smoked at the VA?
A. How many cigarettes cause a haze?
Q. Doctor, do you know how many cigarettes were

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smoked at the VA while Mrs. Wiley worked there?
A. How many cause a haze?
Q. Can you answer that question?
A. I cannot tell you how many cigarettes were smoked.
Q. Do you know how frequently cigarettes were smoked at the VA Hospital when she worked there?
A. How frequently cigarettes were smoked at the VA Hospital.
Q. When she worked there. Do you know that?
A. If someone tells me that they are smoking -- if there was a complete haze over the floor, and that they smelled heavily of tobacco smoke --
Q. What does that tell you about how many cigarettes were smoked at the VA while she worked there?
A. A fair amount of cigarettes.
Q. Well, how much is a fair amount?
A. I don't know. I can't tell you that.
Q. So the answer to the question is you don't know how many cigarettes were smoked at the VA while she worked there.

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A. I'm telling you there was a haze on the floor where she worked and that she inhaled that. That's what I'm telling you.
Q. And what you're telling me is something that someone else has told you. You weren't a witness to it; right?
A. No, her husband told me that.
Q. And you didn't record that --
A. Or she told me.
Q. -- in your medical records, did you?
A. No.
Q. And you don't know how many cigarettes --
A. Why would I make that up?
Q. -- were smoked to produce that haze, do you?
A. How many cigarettes does it take to produce a haze in a ward?
Q. You tell me. Does it take one or does it take more than one?
A. I would suspect it would take more than one.
Q. How many?
A. I can't tell you.
Q. Okay, thank you, Doctor. Do you know how often cigarettes were smoked in that ward?
A. Enough to produce a haze.
Q. Do you know how often cigarettes --

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A. Using her words.
Q. Do you know how often cigarettes have to be smoked to produce a haze?
A. Depends on the quality of air there, depends on the size of the room, depends on the proximity of where she was.
Q. Tell me what you know about the quality of the air, the size of the room, and Mrs. Wiley's proximity of smoke at the VA Medical Center.
A. The proximity of smoke is the fact she felt, and she told us, that she was in that. That's the proximity of smoke.
Q. What do you know about the size of the room and the quality of the air?
A. I don't know anything about the size of the room.
Q. What do you know about efforts Mrs. Wiley made to avoid exposure to environmental tobacco smoke?
A. My understanding -- and I can't remember where this was in this history -- is that she had complained earlier to some of her supervisors about the amount of smoke that she was exposed to.

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Q. Doctor --
A. But I can't -- I don't know where it is. All I remember is that was there someplace.
Q. I can assure you it's not in your admission note.
A. Okay. Then it is not.
Q. Can you point me somewhere else where it might be? Show me where you wrote that down prior to Mrs. Wiley's death.
A. I did not write it down.
Q. Show me where you wrote it down or recorded it prior to the time that Mr. Wiley called you and enlisted your help in making his claim against the VA.
A. I've not talked to Mr. Wiley. I've talked to the attorneys who talked to Mr. Wiley.
Q. So any information you have about that, then, came from the attorneys.
A. Any information that I had having to do with this patient came from the patient's husband who told the attorneys who told me.
Q. All right. And you were relying on the attorneys to fairly, accurately, and completely relay that information to you.
A. Well, I don't see any reason why they

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wouldn't do that. I mean, they're trying to be honest.
Q. They have a financial interest in the outcome of the lawsuit, though. You know that, don't you?
A. I don't know if they do or not.
Q. Attorney Daynard told you that when you called him in May of '93, didn't he?
A. Not that I'm aware of.
Q. He told you that attorneys would take a case like this on a contingency fee, didn't he?
A. They may take the case on a contingency fee.
Q. And you understand what that means, don't you?
A. All I know is if they possibly could win.
Q. They get paid.
A. I don't know. I'm not an attorney so I --
Q. Well, you wrote down contingency fee in your --
A. Well, I quote what he stated.
Q. Okay. Doctor, if everybody --
Well, do you think everybody's been exposed to environmental tobacco smoke at some point in their life?
A. The statistics state and some of the

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literature states that, the general population, it's almost impossible to escape.
Q. Then why isn't lung cancer more frequently observed in lifelong nonsmokers?
A. It has to do with the intensity of the exposure, the amount of exposure.
Q. And the duration of the exposure.
A. Yes.
Q. And the fate of the exposure once it occurs. We had that conversation earlier.
A. The fate of the chemicals.
Q. In the body.
A. Yes.
Q. So that suggests to you, does it not, that there is some level of exposure to environmental tobacco smoke below which there's not a risk of disease or an ability for it to produce cancer in an individual, doesn't it?
A. Disease.
Q. Let's limit it to cancer. I mean, if I understand your last --
A. I can't tell you that. I can't tell you that because of the fact that some

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individual may be exposed to secondhand smoke and, with other factors, may develop cancer; or they may not recall that they were exposed to secondhand smoke and they develop cancer.
Q. How about individuals who may innocently or intentionally recall being exposed to more secondhand smoke than they may have actually been exposed to; you think that ever happens? Do you think people overestimate their prior exposure to a carcinogen or a substance suspected of causing cancer?
A. Knowing human nature, in the patients I've taken care of, they probably underestimate.
Q. Do you think it ever happens that people overestimate?
A. Knowing human nature as I have experienced with patients, I mean, if you ask a drunk or an alcoholic how much they drink, you know, they usually underestimate. If you ask a chronic smoker how much he smokes, they usually underestimate. Unless they're -- I mean, they try to be as truthful as they can, but in certain situations they're scared to death, they're frightened.

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Q. Now, Mrs. Wiley was known to you to be a nurse; right?
A. Yes.
Q. She was known to you to be a nurse that had supervisory responsibilities at her facility; right?
A. Yes.
Q. She presumably had engaged herself in some sort of continuing education during her years as a nurse?
A. She -- what was your question?
Q. Well, do you think Mrs. Wiley -- well, because she was a nurse, would Mrs. Wiley have been obligated to participate in some continuing education throughout her career as a nurse?
A. Knowing the VA system, I can't tell you that. There is a number of nurses that may or may not. Depends.
Q. You don't know and have never seen Mrs. Wiley's employment records to know whether she did that.
A. No.
Q. Do you know whether she was trained to observe and report and record things in

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connection with her job as a nurse?
A. Whether she was --
Q. Trained to observe, report, and record things.
A. I would expect she would but I would not know that for sure.
Q. Do you know whether she believed environmental tobacco smoke presented a risk to her health at the time she began working at the VA?
A. I can't tell you that for sure.
Q. Do you know whether she was an exemplary employee, that is to say somebody who met or exceeded the job description for the position she held?
A. She stayed there for 18 years or whatever, and she reached a supervisory position. I would suspect that she must have done something to earn that.
Q. By the way, Doctor, you didn't need to know the cause of Mrs. Wiley's cancer to treat her, did you?
A. No.
Q. And --
A. Wait a minute. The cause. You're talking

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about the type of cell?
Q. No, Doctor, I'm talking about the etiology of her cancer.
A. Etiology.
Q. You did not need to know the etiology of her cancer to treat her, did you?
A. No.
Q. How would you characterize for me a less than heavy exposure to environmental tobacco smoke?
A. You've asked this question before. Less than heavy. What does heavy mean? I mean, what percentage of particles? What number of particles in a cubic -- I mean, an epidemiologist would be able to tell that to you.
Q. In order to characterize an exposure to a substance as heavy or less than heavy, would you need to know how many -- well, strike that.
You think that people who smoke cigarettes are exposed to higher levels of tobacco smoke than people who are exposed to cigarette smoke passively, as you've defined the term?

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A. Smoke or chemicals?
Q. Chemicals in smoke. Smoke constituents. Do you think the people who smoke cigarettes are exposed to higher levels of tobacco smoke constituents than nonsmokers exposed to environmental tobacco smoke?
A. I've already answered that. The point is. is that, because of incineration, environmental tobacco smoke usually is more toxic and the chemicals have not been totally incinerated and, therefore, environmental tobacco smoke can be more toxic than primary smoke.
Q. Well, Doctor, I'm not talking about toxicity. I'm talking about --
A. The number of chemicals.
Q. Level of exposure. Do you think people who smoke cigarettes are exposed to higher levels of the tobacco smoke constituents than nonsmokers who are exposed to ETS?
A. You're looking at level of exposure. You're looking at whether -- okay.
Q. People who eat five apples a day are exposed to more apples than people who eat two apples a day.

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My question to you, Doctor, is, are individuals who smoke cigarettes exposed to higher levels of the constituents of that smoke than nonsmokers who are exposed to environmental tobacco smoke?
A. First of all, how many cigarettes were smoked by the primary patient? How many cigarettes were exposed to the environmental tobacco smoke? Is it equal? Is it 5/5 or what?
Q. Let's say that we had one person smoke one cigarette.
A. Yes.
Q. Would that person be exposed to a higher level of the constituents of that smoke than an individual sitting across the table from him who was being exposed to the environmental tobacco smoke?
A. Statistics and the papers that I have researched state that environmental tobacco smoke from that one cigarette contains higher levels of chemicals and is more toxic than the smoke that is inhaled by the smoker.
Q. That's your opinion.

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A. That's from the literature.
Q. Well, Doctor, I take it, then, you'd be interested in looking at literature that suggests the contrary; right?
A. Well, get it to me and I'll look at it.
Q. Well, no one's provided you with that literature?
A. I have not found it in the research that I have done. I mean it's from the -- I mean, looking at the people that -- the literature that I have looked at, the U.S. Surgeons General and the EPA and a number of other places.
Q. Are you familiar with literature that suggests that smoking four to five cigarettes a day does not significantly increase your risk of developing lung cancer?
A. Smoking four to five cigarettes a day --
Q. Does not increase your risk of lung cancer.
A. -- does not increase your risk of lung cancer. I cannot tell you that. I mean, I wouldn't smoke one cigarette, let alone four or five. Would you smoke four or five cigarettes?

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Q. Doctor, what I would like to know is what you think, not what your opinion is, but what you think the literature says. The people who studied the subject. Not come to conclusions without studying it. People who studied it.
Do they think, have they published evidence to suggest that smoking four to five cigarettes a day, or less, does not significantly increase your risk of developing lung cancer?
A. If the literature is out there and if you can present it, I will look at it. I mean, I don't want to state that there is no risk of lung cancer.
Q. So you are not familiar with literature that suggests that smoking four to five cigarettes a day does not significantly increase a person's risk for lung cancer.
A. I have not read that recently. If I have, I can't remember.
Q. All right. Do you think that smoking one pack of cigarettes a year for ten years, not one a day, one a year for ten years, could produce lung cancer in an individual?

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A. An epidemiologist would be much more likely to answer that for you. I mean, if genetically, other factors, and that's a number of chemicals that I'm putting in my body, and I would not -- you know. And I think there would still be a risk. How high it is depends on other factors.
Q. How many of the studies that -- epidemiological studies that have been published on the relationship between environmental tobacco smoke and lung cancer demonstrate a statistically significant increase in risk as a result of that exposure?
A. My understanding, there's a number of studies.
Q. Do you know how many?
A. I'd have to look. But I believe a number of studies.
Q. How many studies suggest that exposure to environmental tobacco smoke does not increase one's risk of developing lung cancer?
A. I can't tell you the number, whether there are any and how they've skewed the

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statistics, I can't tell you that. Again, an epidemiologist would be able to tell you that. I mean, I don't have all the literature in front of me.
Q. That literature forms the basis of your opinion, though, doesn't it?
A. Yes.
Q. And how did you familiarize yourself with that literature in order to arrive at your opinion?
MR. CROSS: Well, just for the record, what opinion are we talking about?
Q. Your opinion, Doctor, is that environmental tobacco smoke can cause lung cancer in nonsmokers.
A. Yes.
Q. And you cite in your July 20th letter some -- what do they call them -- reviews, where people have reviewed the literature and summarized it.
A. Yes.
Q. Is that the basis from which you reach that conclusion or have you gone back and actually looked at the studies yourself?
A. I've looked at the literature that has been

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published having to do with the studies, as well as summarized studies.
Q. So you've looked at the studies and you've looked at the review.
A. Yes.
Q. The summary studies.
A. Yes.
Q. And you can't tell us today how many of those studies --
A. You want numbers. I'm just telling you the preponderance of studies have been looked at, and as I said before, from 1981 to '94 there were 30 studies that revealed that there was a causal relationship between environmental tobacco smoke. Now, how many other studies are out there that the leading scientists do not agree with, that do not show that causal relationship, I can't tell you.
Q. Let's back up for a minute Doctor. I think you misspoke. Those studies, those epidemiological studies do not conclude that there -- the individual studies do not conclude there is a causal relationship between exposure to environmental tobacco

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smoke and lung cancer, do they?
A. My understanding is there is a causal relationship. They have shown there's a higher risk of lung cancer in individuals who are exposed to secondhand smoke.
Q. The epidemiological studies have demonstrated a higher frequency of lung cancer in some individuals who have been exposed to other people's smoke; right?
A. In individuals who are exposed to environmental tobacco smoke --
Q. There are epidemiological studies --
A. There's an increased relationship.
Q. -- that demonstrate an increased frequency of lung cancer in those people; right?
A. Yes.
Q. And then, because of that increased frequency, those researchers, using well-known techniques, determine the relative risk of that exposure; right?
A. Yes.
Q. And then, from that information, you and others have concluded that the relationship between environmental tobacco smoke and lung cancer is a causal one. And I understand

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that's your opinion.
But my question to you is, those individual studies, the researchers who did those studies, is it your testimony that in those studies they conclude that that relationship is a causal one? Or do they demonstrate an increased risk, calculate a relative risk, and leave it to you and others to conclude whether or if that is a causal relationship?
A. Well, when I read those studies and when most individuals that are researching this information read those studies, we take that, and I take it, as a causal relationship since the percentages are such that there's no other way to define it.
Q. But my question to you, Doctor, is the people who did that research, are you telling us that they say in those studies this is a causal relationship?
A. I can't tell you, I cannot quote them. I don't have the studies in front of me. But from reading the literature, there is no doubt that environmental tobacco smoke, your risk of developing lung cancer and

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specifically adenocarcinoma is increased --
Q. And my question --
A. -- from environmental tobacco smoke.
Q. My question to you, Doctor, is, based upon that epidemiology, let's limit ourselves to the epidemiology, do those epidemiologists conclude that, as a result of their data, there is a causal relationship?
A. Looking at all the factors that are summarized in some of those articles, I believe that they are stating that there's a causal relationship.
Q. Well, I know that's your opinion, Doctor, but --
A. Well, what else do you want?
Q. Well, if we had all those studies in front of us, are you telling me I could open them up one at a time, and in the conclusion section those investigators would say this data indicates there is a causal relationship between environmental tobacco smoke and lung cancer?
MR. CROSS: Well, I'm going to object, asked and answered five times by my count. If you want to get those studies out

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and ask her to testify what they all say, let's do that.

MR. OHLEMEYER: Mr. Cross, we're going to have plenty of time at trial to do that.

Q. But my question to you, Doctor, is it your understanding that those researchers concluded in those studies that there was a causal relationship between environmental tobacco smoke and lung cancer.

A. I believe what they stated was, their conclusion was the overwhelming evidence, and I think that's been quoted in one of those studies, state that environmental tobacco smoke is related to lung cancer.

Q. It is related because --

A. I'm just telling you the overwhelming evidence --

Q. Well, I understand what you're saying, Doctor. But my point is, do you understand how an epidemiological study works?

A. I'm not an epidemiologist. Maybe you should ask an epidemiologist to use those words. I'm just trying to truthful with you.

Q. Do you think there's a difference between

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demonstrating an increased risk or demonstrating an association between a risk factor and a disease and determining whether or if there's a causal relationship between those two things?

A. Okay, now --

Q. Do you think, is there a difference in your mind between the demonstration of a risk factor for disease in an epidemiological study and a conclusion that that relationship is one of cause and effect?

A. It would certainly lend you towards that relationship, yes.

Q. It would be consistent with the idea that there is a cause and effect relationship; right?

A. What I'm saying is --

Q. Do you understand that question, Doctor?

A. You want me to read the mind of an epidemiologist and speak as an epidemiologist and I'm not an epidemiologist.

Q. All I want to know is what your understanding of epidemiology is, and if you don't have one you can tell me.

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But my question to you is, is it your understanding that the demonstration of an increased risk for disease, based on an epidemiological study, is a synonymous -- or is synonymous with the conclusion that there is a cause and effect relationship between those two things?

A. There is strong evidence that there may be a cause, yes.

Q. There is evidence of but not dispositive of; right?

A. Evidence of --

Q. Let me rephrase the question. Does anyone use epidemiology to prove cause and effect relationships?

A. Well, we use epidemiology to define the risk involved and, I mean --

Q. Is defining the risk involved in a behavior or an exposure the same thing as determining a cause and effect relationship between that behavior and that exposure?

A. That's what they do to define the causality.

Q. Is defining a risk the same thing as determining the cause?

A. Defining the risk is determining the cause.

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Q. Is it the same thing? Is identifying the risks associated with a disease the same thing as establishing a cause and effect relationship between those exposures and that disease?

A. Defining the risk is the same thing as cause. Is that what you're asking?

Q. That's my question. Do you believe that when you have demonstrated a risk, using an epidemiological study, that you have established a cause and effect relationship?

A. I'm telling you that it increases the chance that that is, indeed, the cause of the relationship. And you can't say 100 percent cause, you know? What I'm pointing to you is the fact that the literature in this situation, on environmental tobacco smoke, states -- the overwhelming evidence states that environmental tobacco smoke causes lung cancer.

Q. Yet the epidemiology doesn't suggest that your chances of developing lung cancer -- well, strike that.

The epidemiology doesn't indicate that it is more likely than not that a lung

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cancer occurring in a nonsmoker was caused by exposure to environmental tobacco smoke.
A. You're saying -- rephrase that question.
Q. Well, isn't it a fact, Doctor, that the epidemiology itself is insufficient, is an insufficient basis from which you conclude -- strike that.
You rely on more than the epidemiology to come to your conclusion that environmental tobacco smoke can cause lung cancer in nonsmokers.
A. The epidemiology that's out there in these studies, and the studies that have been completed, and the number, over 30 studies up until 1994, state that, and their summaries state that, because of the evidence that they've looked at, the number of subjects that they've looked at, the exposure, there is evidence, overwhelming evidence that there is a relationship between environmental tobacco smoke and cancer, lung cancer.
Q. And that relationship is expressed as a relative risk: right? Or knowledge ratio in those studies?

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A. Yes.
Q. And when you say "overwhelming," do you mean statistically significant in a 95 percent confidence interval?
A. Since I'm not an epidemiologist --
Q. Well, you understand what a confidence interval is; right?
A. To a certain extent, yes.
Q. Tell us what the significance of a 95 percent confidence interval is.
A. I would suspect, not being an epidemiologist, that there is a significant or a high level of confidence in that data.
Q. As opposed to the result being -- as opposed to the data or the conclusion being the result of chance, mistake, or bias.
A. Yes. Yes.
Q. Doctor, what do you know about the Fontham study? F-O-N-T-H-A-M.
A. It was a study, and I'd have to put it in front of me -- I have it in there, I know, in my office. It had to do with, I believe, secondhand smoke, but I can't remember what -- in what population. You have the study in front of you that I could review?

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Q. Well, I'm just asking you whether or if you make use of that -- whether you're familiar with the study and whether you've used it as one of the bases for your opinions in this case.
A. I can't tell you that. I'd have to look at the study again.
Q. Doctor, let me hand you now what I have marked --
Let me do this, Doctor. Would you find for me your -- excuse me, Doctor, I'd like to ask you --
A. I'm trying to look at the Fontham study that you asked me about.
Q. I'm asking you to tell me everything you can tell me about it right now.
A. I can't tell you because there's a number of studies in this box. I need to --
Q. Do you recall or can you tell me how you used it in forming the opinions you've reached in this case?
A. I'd have to look at the study.
Q. Do you know -- you have read it; right?
A. Yes. But I -- I mean, this was written in 1993. That was four years ago.

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Q. Do you recall when Fontham was published?
A. No.
Q. Do you recall how it --
A. You have it in front of you, don't you?
Q. Do you recall or do you know how it compares to the other studies in terms of how big it was --
A. No.
Q. -- or how well controlled it was --
A. No.
Q. -- or how confident the authors were of their conclusions?
Why don't you take a look at your June 6th bronchoscopy report, which we haven't marked that as an exhibit. I will, but I think --
Do you have it in front of you or do you want me to put it in front of you?
Doctor, let me hand you a copy --
MR. OHLEMEYER: Let me just mark this as the next in order. And then mark this as the next after that.
(Deposition Exhibit(s) 29-30 marked for identification.)
Q. Doctor, let me hand you No. 29 and 30 which

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are the June 6th and July 22nd reports; right?
A. Yes.
Q. Tell me how you went about preparing the June 6th report.
A. That was dictated after I completed her bronchoscopy..
Q. Why do you dictate a report after you complete a bronchoscopy?
A. So there is a written record of that report.
Q. It's your standard practice?
A. Yes.
Q. From what do you dictate? From memory or from notes or --
A. Both from memory as well as notes.
Q. And where would the notes be from which you dictated that?
A. It would be in the progress note.
Q. So we ought to be able to find a progress note that corresponds to that procedure; right?
A. Yes.
Q. All right. Now, Doctor, it says, in the June 6th report, that Mrs. Wiley was admitted on 5/29 with a right lung mass?

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A. Yes.
Q. That's by x-ray; right?
A. Yes.
Q. Dr. Patel had done a bronchoscopy prior to 5/29; right?
A. Yes.
Q. And he didn't observe a right lung mass using the bronchoscope; right?
A. Yes. That's what he stated.
Q. Now, you see the next exhibit, the 7/22 report?
A. Yes.
Q. Tell me why and how you dictated that report.
A. Well, as often happens, I don't know often, but as happens in the hospital, when I got the chart back to sign -- this is when they were still keeping -- and we've only switched to a computer in the last two to three years, this was all by -- we would have charts that were kept in medical records, we would dictate, the dictation would be filed by somebody from medical records, and that's where this came from.
Q. "This" being?

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A. June 6th, '91.
Q. Well, when did you receive that?
A. Well, what I'm stating to you is the fact that, this is what happened, this is the reason why you have two dictations. First of all, when they -- and this happens sometimes with H&Ps, as with surgical reports, with discharge summaries. They will state "this has not been dictated" so we go back and we go back from our notes as well as our memories and dictate another time.
Q. Well, the other time you dictated your report of this procedure was a month after Mrs. Wiley died; right?
A. Yes.
Q. It was almost two months after you did the procedure; right?
A. July 22nd, June 6th.
Q. Okay. And the July 22nd report differs in several respects from the June 6th report; right?
A. I don't know. We'd have to go line-by-line.
Q. Have you gone through this recently?
A. I've read through it.

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Q. Did you read through it with the lawyers last week and Dr. Songer?
A. I have not read it with Dr. Songer, no.
Q. Did you read through it with the lawyers last week?
A. Not last week, no.
Q. When?
A. We went through, they were asking me questions about why there was two dictations.
Q. When did they ask you those questions?
A. Just last night.
Q. How long did you meet with them last night?
A. 45 minutes to an hour maybe, at the most.
Q. What else did -- did they show you these reports last night?
A. Yes, because they wanted to know why there was two dictations.
Q. What else did they show you last night?
A. Well, the hospital chart. The progress notes.
Q. They show you any of Dr. Songer's deposition exhibits?
A. No.
Q. Have you read his deposition?

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A. No.
Q. Have you heard about his deposition?
A. No.
Q. What did you tell them about why there were two reports?
A. Same thing I just told you. That medical records, you dictate a report and they say, "You didn't dictate it," and you cuss and you say, "Yes, I did," and they say, "No, you didn't," and you dictate another one and both of them end up in the medical record.
Q. Do you ever watch the program ER?
A. Occasionally. I don't have much time to watch television.
Q. Did you watch it last Thursday?
A. No.
Q. You sure?
A. I've got so many patients, I don't have time to watch television. What was it about?
(Discussion off the record.)
Q. Doctor, one other question. Back, I don't mean to press this about your father, but do you have any health-related problems that you attribute to your father's cigarette smoking?

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A. I have asthma.
Q. Do you attribute your asthma to your father's cigarette smoking?
A. It's difficult to state, say that, because, since my asthma began at the age of 18 and I had moved out and I was in school, but it's difficult to define yes or no whether that is related to me.
I do have multiple allergies. And my father had allergies, some allergies, but not as -- I have multiple, multiple allergies.
Q. Are you allergic to fragrances?
A. Yes.
Q. Do you -- I mean, does it bother you if people wear perfume or aftershave in your presence?
A. Yes.
Q. When did you associate or consider whether your asthma might have been associated with your father's cigarette smoking?
A. Well --
Q. I'm not looking for a date. I mean, was it during medical school? Was it while you were living at home? Was it yesterday? You know what I'm saying.
A. No. From about the age of 18 on I developed asthma, a certain amount of asthma. But in the last, probably the last 14 years it's gotten much worse.
Q. So within 14 years ago did you begin to consider whether or if your asthma may have been associated?
A. It's difficult to say. Probably off and on. Off and on. It's hard to say. I mean --
Q. Off and on as long ago as 14 years ago.
A. Or even longer.
Q. Back to the two exhibits in front of you which are Nos. 29 and 30, Doctor. There's a change in the July 22nd report from the June 6th report about the reasons for Mrs. Wiley's admission. Can you tell me why you made that change?
A. Was admitted on 5/29 with a right lung mass, as well as severe bone pain. And that was from the June 6th. A myelogram revealed significant necrosis of L2 pedicle. Bone scan revealed widely metastatic lesions in the skull and femur.
The other one, on July 22nd, was

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admitted with severe shortness of breath, as well as partial collapse of the right lower lobe. The patient had evidence of a metastatic lesion of the bone and lumbosacral spine. To obtain specimens. Highly suspect that she may have a lung cancer.
I don't consider those that significantly different.
Q. They're different, though, aren't they?
A. Well, yeah, but --
Q. They contain different facts?
A. Well, essentially the same facts, as she did have bone pain, she had a right lung mass, and there was partial collapse of the right lower lobe on the 22nd. You know, on the July 22nd. I don't consider them that different.
Q. Well, the June 6th report doesn't say it was highly suspected she may indeed have lung cancer, does it?
A. She had a right lung mass.
Q. It doesn't say it was highly suspected that she may indeed have lung cancer, does it?
A. She had a right lung mass.

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Q. Doctor, this is a simple question. Does the June 6th --
A. I know it is. But you're asking, as a physician --
Q. Well, my --
A. -- if somebody has a right lung mass, then -- I mean, what we're doing is a bronchoscopy to obtain specimens. The patient had severe bone pain, she had necrosis of the L2 pedicle, and there was widely metastatic lesions in the skull and femur, was needed to affirm a primary lesion.
Q. When Mrs. Wiley was admitted on the 29th of May you had an x-ray.
A. Yes.
Q. That may or may not -- that the radiologist who reviewed it said may or may not represent a lung mass; it may also represent an atypical pneumonia. Right?
A. Let's look at that. Let's look at the x-ray, okay?
Q. It doesn't have to be that complicated, Doctor. My question to you is, isn't it a fact that there is a sentence in the July

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report that is not in the June report, and that sentence is "It was highly suspected that she may indeed have lung cancer"?
A. What does the other report say?
Q. Well, it does not say it was highly suspected that she may indeed have lung cancer; right?
A. To affirm a primary lesion. "Bronchoscopic evaluation was needed to affirm a primary lesion." On June 6th. So therefore, a primary lesion is a lung mass.
Q. Well, Doctor, I'm not going to quibble with you, we'll let the jury decide whether it does or it does not say it was highly suspected.
A. Well, I'm just telling you, from a physician's standpoint, these are the same histories.
Q. Well, my question to you is, that's my question. Even though there are two different descriptions here, your testimony is these were the same histories, admission histories.
A. From the same situation, yes.
Q. All right.

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A. Just because you use different words doesn't mean you don't mean the same thing.
Q. Well, that's your testimony.
Now, Doctor, you didn't mention severe shortness of breath in your 5/30 admission history, did you?
A. 6/6 or 7/22?
Q. 5/30. May 30 admission note. Doesn't say anything about severe shortness of breath; right?
A. Let's see here. Let me look through here.
Q. Doctor, let me just, to move this along, I'll just withdraw the question because it doesn't, and I really don't need you to agree or disagree with me. We can establish that pretty simply.
MR. CROSS: We're making progress now.
THE WITNESS: Well --
Q. Let me ask you this, Doctor. Do you mind, Doctor?
A. Yes. Fine. Go ahead.
Q. In June, on June 6th of 1991, you've got a woman who you suspect is having a primary carcinoma of the lung; right?

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A. Yes.
Q. You have a history --
A. Well, I don't know if she's got a primary or not. I'm saying she's got a lung mass on her x-ray, she's got a full right hilum, she's got volume loss, she's got metastatic lesions to the bone. You know --
Q. She's got a history of environmental tobacco smoke exposure; right?
A. She had that, yes. We surmised that.
Q. And so you're doing a bronchoscopy on June 6th and what you're looking for is an endobronchial lesion; right?
A. What I'm looking for, this lady came in -- this lady came in with bone pain. Lower lumbar bone pain. Well, when she came in, we were concerned that there was something eating away at her bone.
Now, when we look at the entire picture, she had an abnormal chest x-ray. That's when -- and with her history and the fact that she had a cough, the fact that she had hemoptysis, or coughing up blood, the fact that she had been sick for some time, then we decided that -- I mean, look at the

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whole picture.
Q. And what you were looking for would -- I mean, an endobronchial lesion would be consistent with the picture of a primary carcinoma of the lung in an individual with a history of environmental tobacco smoke exposure; right?
A. You can get lung cancer from environmental tobacco smoke.
Q. And you had a woman who you knew and believed to have been exposed to environmental tobacco smoke; right?
A. Yes.
Q. You suspected she had a lung cancer.
A. I suspected from the history, from the clinical presentation, from the right hilar lesion, from the CT report.
Q. And so you did a bronchoscopy.
A. Yes.
Q. And a significant observation in that bronchoscopy would have been the finding of an endobronchial lesion, in your opinion.
A. We found that she had an endobronchial lesion.
Q. As you put the scope into Mrs. Wiley's

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body --
A. Yes. Yes.
Q. -- you're saying to yourself, I'm looking for an endobronchial lesion.
A. No, I wouldn't say that. I'm looking for tissue. You're putting words in my mouth. I'm looking for tissue. I was not suspecting an endobronchial lesion. I did not do the bronchoscope looking for an endobronchial lesion. I was looking for a source and a primary that would explain the rest of her symptoms.
Q. And in the June 6th report, you note the absence of an endobronchial lesion in the right lung.
A. Okay. What it says here, okay, this is in relation to the carina. "The carina appeared to be markedly broadened anteriorly," which means that there are lymph nodes involved in the subcarinal area. "The left upper, lower, and lingular segments were inspected carefully. All segments were patent," which means they were open, "and appeared normal."
Q. My question is, is once you put the

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bronchoscope into the right main stem, you didn't find any evidence of endobronchial lesions.
A. In the right -- "upon entering the right upper lobe segments, marked mucosal mounding was noted."
Q. And no evidence of endobronchial lesions were noted in the right upper lobe.
A. No evidence of endobronchial lesions were noted in the right upper lobe.
Q. "However, with insertion --"
A. "Insertion of the bronchoscope into the bronchus intermedius, there was total occlusion of the airway."
Q. There's a period there, isn't there?
A. I know but that's -- that has to do with dictation and has to do with when they -- just like she is. She's trying to put all this together as we're talking. You know, they're going to do the same thing.
Q. Well, Doctor, you read this dictation, don't you?
A. Yes.
Q. And you're doing it for a reason; right? That's to create an accurate and complete

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medical record. Right?
A. I'm reading the dictation to you right now, yes.
Q. No, when you, in June, when you dictate this.
A. Yes. Well --
Q. This isn't an idle, superfluous task for you, is it? It's important, isn't it?
A. Well; yes.
Q. And it says right here that there was no evidence of endobronchial lesions --
A. Were noted.
Q. -- noted.
A. "However, with the insertion of the bronchoscope into the bronchus intermedius, there was total occlusion of the airway with tumor and mucosal edema."
Q. And it does not say, in your impression here, that you have endobronchial lesions, does it?
A. "Primary neoplastic process right main stem with total occlusion of the bronchus intermedius and obstruction of the middle and lower lobe segments." That's what it says.

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Q. It does not say in the June 6th dictation that you have probable carcinoma of the lung with metastatic lesions to both vertebrae as well as to the chest wall, does it?
A. In June 6th, my bronchoscopy note --
Q. Does not say probable carcinoma of the lung with metastatic lesions to both vertebrae, as well as to the chest wall, does it?
A. No.
Q. The June 6th report does not report any abnormality of the right main stem bronchus, does it?
THE WITNESS: Go back to the question before this.
(The requested material was read back by the reporter.)
Q. Those words do not appear there, do they, Doctor?
A. No.
Q. They do appear in your July dictation, do they not?
A. Yes.
Q. And the statement, "the impression of widened carina suggestive of extensive mediastinal lymph nodes --"

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A. Yes.
Q. -- is likewise not contained in your June 6th report, is it?
A. Well, what it says is the left -- the carina appeared to be markedly broadened anteriorly.
Q. Under the impressions, 1, 2, 3, does it say widened carina suggestive of extensive mediastinal lymph nodes?
A. That's what it says, yes.
Q. In the July report.
A. Yes.
Q. It does not say that in the June report, does it?
A. No.
Q. All right. Now, Doctor --
A. That does not mean -- in my dictation it says "markedly broadened anteriorly." That means, if you look at the carina, and it is broadened, that is a sign of subcarinal infiltration of tumor into the lymph nodes.
Q. What's the point, Doctor, of listing these impressions the way you do here with a big, all capital "IMPRESSION: 1, 2, 3"?
A. After doing the bronchoscopy and after we gathered the information, we're trying to make an impression of what we believe is going on.
Q. And am I correct that the impressions described in your June report are different than the impressions described in the July report?
Let's put it this way: The language you used to describe those impressions is different in your June report than it is in your July report.
A. The language described is different, but it doesn't mean -- it doesn't seem -- say the same. It means I didn't mimic my two reports.
Q. Why did you mention suspect squamous cell in the first report but not in the second report?
A. Because when I saw the endobronchial lesion, that is most -- you see that most frequently -- I mean most typically, the way it appeared, was a squamous cell carcinoma.
Q. Well, but we're only talking about one bronchoscopy here; right? Just two different dictations; right?

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A. Yes.
Q. In the first one, you say "suspect squamous cell" --
A. Yes.
Q. -- as one of your impressions. You don't include that in the second one, the July one. Why not?
A. Because it's a different time. It doesn't mean that it's not there. It just means that I dictated it after the first one.
Q. You dictated it --
A. I mean, if you dictate two letters and don't look and read it off, do you dictate it exactly the same or do you change it?
Q. Well, you changed this one, didn't you?
A. I didn't change it. I just dictated it differently.
Q. And in the second one, the July one -- strike that.
You don't include the impression of suspect squamous cell in the July dictation; right? The July report.
A. It does not say that I did, yes.
Q. Now, you dictated the July report after you had dictated the death summary, didn't you?

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A. Well, what day is the death summary dictated? Okay, the 21st.
Q. So you dictated the second report of the bronchoscopy after you dictated the death summary.
A. Yes.
Q. So you dictated the second report of the bronchoscopy after you had concluded that Mrs. Wiley suffered from a metastatic adenocarcinoma of the lung secondary to secondhand smoke.
A. Yes.
MR. OHLEMEYER: All right. Can we take a very quick break and then let me try to wrap this up. We've got to get out of here by 5; right? Let me take a quick break.
(A recess was taken.)
Q. Dr. Turner, if you don't understand a question I ask will you let me know?
A. Yes. I don't understand about ER; what was that about?
Q. Well. you know, just wondering.
Do you recall Mr. Wiley calling you or your office and asking for a copy of the

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autopsy report?
A. If he did, I'm not aware of it. I mean, he may have, I can't remember.
MR. OHLEMEYER: Well, let's mark this as the next in order.
A. He must have.
(Deposition Exhibit(s) 31 marked for identification.)
Q. It's a telephone note, Doctor. to you: right?
A. Yes.
Q. Dated?
A. September '91.
Q. That's three, four months after Mrs. Wiley died?
A. Yes.
Q. Do you recall talking with Mr. Wiley about the autopsy at that point?
A. I do not recall that I talked to him. If I did, I don't recall.
Q. Do you recall or have you become aware by any reason why he was calling to ask for the autopsy report? Do you know anything about that?
A. No. I mean, a number of patients call and

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ask for autopsy reports. It's not unusual to have that happen.
Q. Do you find that people do that who are dissatisfied with the care they've received or their patient -- their family members have received at the hospital?
A. You know, it's interesting, in 14 years of practice, I've never had anybody ask for an autopsy report -- first of all, I can't think of a time I've been sued. That I can remember. I would think I would remember that.
Q. And you can't ever remember somebody calling and asking --
A. Calling and saying that I was dissatisfied with the care and, therefore, I want the autopsy report.
Q. Can you recall anyone calling and asking for the autopsy report for any reason?
A. Yes. That's what I just said. I mean, they -- people have autopsies, they have questions, they want the autopsy report, and we send it to them if they request it. That's their -- I mean, that's their right.
Q. Doctor, let me hand you a copy of a page

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that is contained in Exhibit 15 that was previously produced in your prior session of deposition. Can you explain that for me?
MR. WAGNER: Is that Exhibit 32?
MR. OHLEMEYER: No, it's part of Exhibit 15.
Q. Says "Roger Johnson" at the top. What's the next word say there? Marion VA?
A. I can't read it.
Q. Something director?
A. I can't read it. I can't read it. Says where or when or where does something treatment stop, we need to fax a --
Q. Fix a point?
A. I don't know. I don't know.
Q. And who did you write this note to? That's your note; right?
A. No, that's not my writing. My writing is "What does this mean? NC Turner." I don't know anything about the other.
Q. Okay.
A. I mean, I don't even know if I figured out what that meant.
Q. So you don't have any idea what that means?
A. No. I mean, it does if you can explain it

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because I can't. "Where does --"
Q. I'm asking you, Doctor.
A. I can't read the -- Roger Johnson, I don't know who Roger Johnson is. And I can't -- where does something stop. Treatment stop; I don't know what that is. We need to either fax or fix; I don't know which one. Where, when something, picks it up. That's all I know.
Q. Doctor, is it fair to say that a factor, if not one of the most important factors in the process by which you reached your opinion about the cause of Mrs. Wiley's cancer was your inability to identify or rule out her exposure to other carcinogens?
A. The question is, is the reason -- now, the question is --
Q. My question, Doctor, is, how big a role, or how big a factor is it, in your opinion, the process by which you came to your opinion, was your inability to identify another potential cause of Mrs. Wiley's disease?
A. There is no factor. I mean, I would not put that on a death certificate. I would not dictate that in my death summary if -- just

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because I didn't have any other etiology I would do that and would just kind of pull it out of the air?
Q. Well, tell me, then, what process, by what process or by what method you ruled out other potential etiologies in this case.
A. Well, the lady was not a primary smoker, she had no other risk factors that we were aware of, other than --
Q. That's my question.
A. -- environmental tobacco smoke.
Q. What effort did you make or how did you investigate her exposure to other risk factors?
A. Other risk factors being?
Q. Did you ask her whether she was exposed to asbestos?
A. I may have or may have not. If it's not in the dictation I can't tell you whether I did or not.
Q. Did you ask her whether she was exposed to any other carcinogens?
A. Carcinogens from?
Q. Carcinogens.
A. Well, you don't always ask that from a

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patient. I mean, what you do is you take a history, you get as complete a history as you can, and you go and look at the investigation. And again, when this lady came in, she had bone mets, and it was only after a thorough evaluation, looking at all the evidence, that we came up with primary lung cancer.
Q. But my question, Doctor, is how did you assemble any evidence about her potential exposure to other risk factors?
A. From my H&P. I mean, if she had been exposed to asbestos, I would have put that down there.
Q. Do you know whether -- you can't tell me whether you even -- whether you asked her that question, did you? Did you ask her, "Were you exposed to asbestos?"
A. It's not in my dictation.
Q. Did you ask her whether she had been exposed to radon?
A. It's not in my dictation.
Q. Did you ask her about her diet?
A. No, I did not ask her about her diet.
Q. Did you ask her whether she had been exposed

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to any other chemicals suspected of causing cancer?
A. If you look at the reasons of why people develop -- first of all, again, we had a patient that came in with metastatic tumor, we had a patient that had some type of lesion invading their bone. When I took this history, when I took the H&P, I was looking at why this patient had an abnormal chest x-ray, and of all the things that happened to her, what my most likely course of investigation would be.
Q. But that was to diagnose her and treat her; right?
A. Diagnose and treat her.
Q. Now we're talking about determining what caused her disease.
A. Yes.
Q. What effort did you make to determine what other things she might have been exposed to that could have caused her disease?
A. Well, the top sources of lung cancer include primary or secondary smoke. I did not ask her about radon; most individuals aren't aware of that.

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Q. So how could you rule it out in this case?
A. Because it's such a small level of incidence, I mean, it did not come up.
Q. Well, you didn't ask her about it, did you?
A. No. Apparently I didn't. Most people don't -- do you know if there's radon in your house?
Q. How do you rule out an etiology in this case that you haven't been made aware of?
A. You look at the statistics and you look at what's the most likely cause.
Q. My question, Doctor, is exposure to environmental tobacco smoke the most likely cause of lung cancer in a nonsmoker?
A. Is --
Q. Look at the statistics.
A. Yes.
Q. Based on the statistics --
A. There's approximately 4,000 --
Q. -- is environmental tobacco smoke --
A. -- lung cancer deaths due to environmental tobacco smoke.
Q. And are there more or less than 4,000?
A. There's approximately 4,000 nonsmoker tobacco deaths due to radon. Now, in this

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situation --
Q. So using the statistics -- bear with me, Doctor. Using the statistics, environmental tobacco smoke is not the most likely cause of lung cancer in a nonsmoker, is it?
A. I mean, it sounds -- if there's 4,000 and 4,000 --
Q. Then the answer is, it is not the most likely cause of lung cancer in a nonsmoker, if those numbers are correct.
A. If those numbers are correct. However, in this situation --
Q. In fact, Doctor --
MR. CROSS: Let her finish her question. Quit arguing with the witness, let her finish.
Q. Let me ask you this.
MR. CROSS: Let her finish the answer.
A. In this situation --
Q. Say whatever you want.
A. In this situation, with the exposure that I had, I mean, you look at the entire situation, you don't --
Q. I understand. You can only do what you can

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do and you can only do based on the information you have.
But my question, Doctor, is, leave aside diagnosing and treating. I'm not suggesting to you that you didn't diagnose or treat this woman correctly. What I'm asking you is, when it comes time for you to do something you did not have to do to diagnose and treat her, and that is to tell somebody, including a jury, including a judge, or including a room full of lawyers what you think was the cause of this woman's disease, I want you to tell me how you ruled out the possibility that something other than environmental tobacco smoke might have caused her disease.
Can you do that for us?
A. I took what the most likely culprit was in this situation and diagnosed that.
Q. And is it your opinion, Doctor, that the most likely cause of lung cancer in a woman who does not smoke, who is not living with a smoker, but who claims a prior exposure to environmental tobacco smoke, is that prior exposure to environmental tobacco smoke?

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A. Does she have an increased risk of lung cancer, yes.
Q. The question is, is it the most likely cause of that disease in that individual?
A. In this situation, secondary to environmental tobacco smoke, I think you have to consider that in your differential.
Q. My question to you, Doctor, and they're your words, is it the most likely cause of lung cancer in an individual who is not a smoker, who does not live with a smoker, who claims a prior exposure to environmental tobacco smoke?
A. You're asking, is -- ask the question again. You keep moving it around.
Q. Well, Doctor, quite honestly, I'm using your words. Is exposure to environmental tobacco smoke the most likely cause of lung cancer in a nonsmoking woman who does not live with a smoker who claims a prior exposure to environmental tobacco smoke at work?
A. Depends on the exposure and it depends on the type of cancer.
MR. YOUNG: 5:00 buzzer.
Q. And do the statistics --

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MR. YOUNG: They've been in here twice. Bill.
MR. OHLEMEYER: Well, then we'll just have to continue later.
(Discussion off the record.)
Q. Doctor, I'm still -- I understand that you have an opinion about the cause of Mrs. Wiley's cancer.
A. Yes.
Q. And we've asked you about when and how you formed that opinion. But the question I have is a little bit different and it relates to how you ruled out other possible causes of that cancer. And I want you to describe for me the process by which you ruled out the other possible causes of her cancer.
A. By my history and by her clinical presentation and by what she told me during the time that she was with me and her husband told me during the time that she was a patient on that ward.
Q. So once you heard her history and once you arrived at a diagnosis of her disease, you had all the information you needed to reach

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a conclusion about the cause of her disease.
A. Once I had her history, talked to the family, looked at her risk factors from the history that was given to me, both in my H&P as well as through the how many days I took care of her, ruled out other -- I mean, as far as a normal, I would like you to look at number of -- I mean, it is not normal. I mean, to ask about radon because, I mean, that is somewhat reaching.
Q. How many doctors in 1991 do you think were asking their patients whether they've been exposed to environmental tobacco smoke?
A. I don't know. I can't tell you that.
Q. Do you think some doctors might have thought that was reaching in 1991?
A. It depends on their educational level, it depends on their interests, what kind of experience they have.
Q. And their bias? And by bias --
A. It's not bias.
Q. Doctor, by bias I mean how they approach a subject and how they analyze a subject?
A. Their bias.
Q. Some people have a, I mean -- well, strike

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that.
You said you looked at other risk factors; what other risk factors did you look at?
A. Whether she was a primary smoker.
Q. What else?
A. Well, her history in the fact that she did not -- I mean, if she said that she had been exposed to asbestos, I would have put that in there.
Q. But we've already established, Doctor, that you probably didn't ask her that question; right?
A. From the -- I can tell you what's in the history and if it's not in the history --
Q. If you had asked her that question, the history would say denies exposure to asbestos; right?
A. Yes.
Q. Okay. The history doesn't say denies exposure to asbestos, the history doesn't say denies exposure to radon, the history doesn't say anything except denies --
A. Primary smoker.
Q. -- tobacco and alcohol; and exposed to

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environmental tobacco smoke.
A. Yes.
Q. So is that the extent to which you looked at other risk factors?
A. During the time I took care of her, yes.
Q. So how did you rule out the possibility that Mrs. Wiley was exposed to or in proximity to a risk factor that she didn't tell you about, either because of inadvertence, ignorance, or some other reason?
A. How did I rule out other risk factors; is that what you're asking?
Q. There came a point in time where you had to sit down and say to yourself, I've diagnosed this woman, I've done everything I can to treat her --
A. Yes.
Q. -- and now I'm going to decide what caused her disease.
A. I'm going to decide the most likely cause, yes.
Q. And in doing so, my question to you is, aside from the history you have in front of us, what effort did you make to investigate or rule out other potential causes of lung

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cancer in nonsmoking women?
A. I mean --
Q. Maybe -- are you telling me it's not that complicated? You've got a nonsmoking woman who's exposed to environmental tobacco smoke?
A. I'm just telling you that when you take a history and you look at the most likely diagnosis, the fact when we did the biopsies and the biopsy -- the transthoracic biopsy, this was consistent with adenocarcinoma.
Q. Let me stop you right there. Adenocarcinoma of the lung doesn't tell you that you're dealing with an adenocarcinoma caused by environmental tobacco smoke, does it?
A. No.
Q. The mere diagnosis doesn't suggest the etiology, does it?
A. The diagnosis of adenocarcinoma, adenocarcinoma does occur in environmental tobacco smoke exposure.
Q. A diagnosis of adenocarcinoma does not compel you to conclude that your patient suffers from a cancer caused by environmental tobacco smoke; right?

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A. Adenocarcinoma can occur in, and, in fact, I believe it's the highest type of cancer in environmental tobacco smoke. And the fact that this was an endobronchial lesion, the fact that this lady told me, and her husband told me throughout the stay or -- or several times through the stay that she had been exposed to environmental tobacco smoke, that she worked in a haze --
Q. So that's my question, Doctor, is what more did you need to know beside the fact that you had a patient with adenocarcinoma of the lung, that you believed to have arisen in the bronchus, who claimed a history to exposure to environmental tobacco smoke to conclude that this was the cause of her cancer? I mean, is that all you needed to know?
A. In my differential and from my examination of her and from all the information I had from the biopsies and everything, that was my diagnosis.
Q. So you didn't look at any other risk factors except for primary smoking, alcohol, and environmental tobacco smoke.

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A. Well, the thing is, asbestos is usually --
Q. Doctor, can you answer that question?
A. I'm trying to explain it to you.
MR. CROSS: She's trying to. Let her.
A. I mean, you don't look at a patient and you split them up into little squares. What you look at is the H -- what you look at is the presentation. This was an endobronchial lesion. It was a central lesion. If this was asbestos, I would expect we would have had a -- you would have had calcification, we would have had a different presentation than what was presented.
Q. Well, what is it about her presentation that led you to believe that the cause of her disease was environmental tobacco smoke? Presentation. Not history.
A. She had a cough.
Q. Let me stop you there.
A. Yes.
Q. Do individuals with coughs inevitably have cancer?
A. Okay. Individuals with coughs inevitably have cancer. Well, there's lots and lots

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and lots of people with coughs.
Q. I interrupted you, Doctor, go ahead, tell me what it is about Mrs. Wiley's presentation that led you to believe she had a cancer caused by exposure to environmental tobacco smoke.
A. Her presentation was she had a lung mass. She had a cough. She had hemoptysis. Normally people do not have hemoptysis for several months unless there's some type of process occurring. That is a significant process. The fact that she had metastatic --
Q. Does that process necessarily have to be cancer?
A. Hemoptysis?
Q. Can it be an infection?
A. It could be an infection, AFB; Mycobacterium tuberculosis. It could have been that, yes. You're asking about hemoptysis and a cough, in a patient with weight loss, that presentation could be consistent with tuberculosis.
Q. But here's my point. If I walk down to one of your partner's offices and they got a

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chest x-ray on the thing, and they say I got a patient with an abnormal chest x-ray, hemoptysis and a cough, you don't say environmental tobacco smoke lung cancer, do you?
A. No.
Q. Because you need more information; right?
A. I would say risk of lung cancer. Or --
Q. Caused -- you don't say risk of lung cancer caused by environmental tobacco smoke, do you?
A. No.
Q. You need more information.
A. From that information that you gave me.
Q. So my question to you, Doctor, is really simple: What information did you assemble or collect about Mrs. Wiley's exposure to other substances that can cause lung cancer before you reached the conclusion that she had an adenocarcinoma of the lung secondary to secondhand smoke?
A. Again, which is what I've explained before, has to do with the presentation. Asbestos, there was no evidence of calcification peripherally. The presentation was not the

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same. If she had had calcification in her chest x-ray, or in the CT scan, we would have said -- we would have come back to her and said, "Have you had exposure to asbestos? We see calcification here." But that's not what happened.
Q. Well, what do you see in a lung cancer that might be caused by exposure to radon that makes it different looking than a lung cancer that might be caused by exposure to tobacco smoke or environmental tobacco smoke or polyvinyl chloride or formaldehyde or benzene or arsenic?
A. Okay, now, your question was, what's the difference from --
Q. Well, you're telling me lung cancer that you associate with an exposure to asbestos presents differently because it demonstrates objective findings that you associate with a prior exposure to asbestos; right?
A. Yes.
Q. Same questions about other suspected carcinogens. What is it about the presentation of a cancer in an individual who has a lung cancer that indicates to you

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it was caused by exposure to tobacco smoke as opposed to environmental tobacco smoke as opposed to formaldehyde as opposed to arsenic as opposed to radon?
A. Where were you going to pick up a high enough level of formaldehyde and arsenic to cause, I mean, except in environmental tobacco smoke. I mean, you're kind of putting those in different sections here.
Q. Well, where, Doctor, are you going to look at somebody's presentation and determine how much environmental tobacco smoke they were exposed to?
A. Has to do with their history.
Q. History. Because you can look at somebody's presentation with asbestos and make some reasonably certain conclusions about their level of exposure based on their objective findings; right?
A. Not really.
Q. Well, let's talk about asbestosis. People don't develop asbestosis living in a house with asbestos pipes; right?
A. They do or do not?
Q. Do not.

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A. It has to do with whether they're exposed to it.
Q. And people who develop asbestosis --
A. Because asbestos particles --
Q. You've got to let me finish.
When you look at an x-ray and you see asbestosis, or you see radiological and pathological findings that allow you to diagnose asbestosis, you know something about the level of exposure to asbestos that individual encountered, don't you?
A. I can't tell you about the level of exposure.
Q. You know it was occupational.
A. Doesn't always have to be. It can occur in their house, it can occur in their schools. But the level -- I mean, the fact that asbestosis, I mean -- well, doesn't matter. Go ahead.
Q. The fact of the matter is, Doctor, you can't look at Mrs. Wiley's lung cancer without the history and say this is a lung cancer caused by exposure to environmental tobacco smoke; right?
A. The one reason -- a major reason that was

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done is because of its location, because --
Q. Doctor, let me ask the question again, I don't mean to interrupt you.
MR. CROSS: Then don't.
Q. Without knowing the history, you can't look at the lung cancer and say this is a lung cancer caused by exposure to environmental tobacco smoke; right?
A. Without knowing the history, I cannot say that that endobronchial lesion was not related? Is that what you're asking?
Q. No. Was caused by exposure to environmental tobacco smoke.
A. Well, looking at -- adenocarcinoma is usually a peripheral presentation. It does not occur very frequently in the airway. The air- -- I mean, it's usually a mounding up. It's usually a peripheral lesion. I mean --
Q. What's the route of exposure to radon?
A. Inhalation.
Q. So --
A. Well --
Q. Tell me how you look at a lung cancer in somebody.

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A. It's radioactive. Essentially exposure.
Q. Tell me how you look at a lung cancer without a history and tell me it was caused by exposure to radon.
A. Tell me how -- do it again.
Q. My question to you, Doctor, is can you look at a lung cancer without knowing a person's history and determine what its cause was absent some sort of pathological manifestation of a prior exposure to the substance like you have with asbestos; plaques, scarring, fibrosis, those kinds of things.
A. Was it an endobronchial lesion? Was it a peripheral? Is that what you're asking?
Q. Let's put it this way, Doctor: Dr. Kocoshis looked at this lung cancer under a microscope; right?
A. Yes.
Q. He didn't say it was caused by exposure to environmental tobacco smoke based on his observation of the tumor; right?
A. He did not say that.
Q. You have concluded that this was a tumor caused by exposure to environmental tobacco

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smoke; right?
A. Yes.
Q. And you've done that based on the history you took from Mrs. Wiley.
A. And the presentation.
Q. If you didn't have the history, you couldn't come to the same conclusion, could you?
A. Well, you'd have to explain an endobronchial lesion that had been going on that was an adenocarcinoma.
Q. And now we're right back to my question. How did you assure yourself that something other than environmental tobacco smoke didn't cause Mrs. Wiley's cancer?
A. You're asking me to diagnose something -- you're asking me to --
Q. Rule out other potential causes of Mrs. Wiley's cancer.
A. Even though -- even though it's -- even though the most likely cause, and the most likely exposure is there and that's the history they gave you. What you're asking me to do is change her history.
Q. What I'm asking you to do, Doctor, is to tell me, first of all, the only exposure

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they gave you was environmental tobacco smoke; right?
A. They told me they were exposed to environmental tobacco smoke, yes.
Q. And we've already established that the statistics necessarily don't suggest that is the most likely cause of her cancer; right?
A. They're about equal, 4,000 and -- in nonsmokers.
Q. Trust me, we'll get the statistics out and we'll let the jury decide whether they're equal or not.
But my question to you is --
A. And again, it's in --
Q. -- is how --
A. And again, it's in nonsmokers.
Q. How did you go about ruling out other potential causes of the disease?
A. If you're asking if she was exposed to radon, I did not ask that. At least it's not documented here.
Q. So let's start right there. How did you rule out the possibility that radon might have caused her cancer?
A. How did I rule that out?

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Q. Exactly.
A. I did not ask but that doesn't mean -- I mean, the point is, is that her presentation was such, I mean, if -- if somebody comes to you and is drinking a 12-pack a day of beer, you don't say, Well, this patient -- I mean, you look at what's the most --
Q. What if somebody comes to you, Doctor, and says I live in a house where we've demonstrated the presence of radon above the level that the EPA says should require some action on my part to abate that radon.
A. Yes.
Q. Would that be something you'd want to consider in determining whether or if radon played a role in causing that cancer?
A. Yes.
Q. All right. My question to you is, how did you go about assuring yourself that that type of information for radon or other carcinogens didn't exist with respect to Mrs. Wiley?
A. If I did not ask her about radon, it's not here.
Q. Or anything else.

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A. What else is there?
Q. Well, there are other things that are suspected of causing lung cancer in individuals besides radon, asbestos, and tobacco smoke; right?
A. But they're very, very rare.
Q. Well, what effort did you make to determine whether or if Mrs. Wiley was exposed to any of those things?
A. So you're saying that I should ask her about vinyl chloride and --
Q. Doctor, here's what I'm saying to you, if you're going to come to court and offer an opinion --
A. Yes.
Q. -- about the cause of this woman's disease --
A. Yes.
Q. -- which is an opinion that you've agreed with me was not necessary to your diagnosis or treatment of her, I want to know the process --
A. Wait a minute. Wait a minute. Rephrase this.
Q. Let me rephrase the question. I want you to

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tell me the process by which you -- here's what I want to do. I want to critically analyze your opinion.
A. Yes.
Q. And to do that I want to know how you arrived at your opinion. And I want to know whether or if you considered and ruled out Mrs. Wiley's potential exposure to other carcinogens. I mean, it's not really as adversarial as it sounds. That's exactly, you know, what I'm trying to do.
A. What I did is I took a history and her history was such that she had been heavy exposure to secondhand smoke, okay? She was not a primary smoker. I diagnosed when I did the bronchoscope --
It's not like you set it up so that I am out there looking for a case such as this. The only -- the only diagnosis that would fit, in this situation, from all the history that I had, including an endobronchial lesion, including the presentation, including all the things that I had, was related to environmental tobacco smoke. And I'm sorry --

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Q. Well, let's put it this way. I think we understand each other. This is not what you do every day at the hospital; right?
A. These depositions?
Q. No.
A. No.
Q. Trying to determine, you know, trying to engage in an exercise to determine what might have caused somebody's death who died six years ago; right?
A. Okay. You're asking -- okay. The patient died six years ago and now I'm trying to decide?
Q. Dr. Turner, you understand why we're here; right?
A. Yes.
Q. Why we're here is because Mr. Wiley, as is his right, is going to ask a jury to determine whether environmental tobacco smoke caused his wife's disease.
A. Yes.
Q. You understand that.
A. Yes.
Q. And you understand that you were involved in that exercise not because it has any effect

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on Mrs. Wiley's diagnosis or treatment; right? Because, unfortunately, Mrs. Wiley is dead.
A. It has to do with diagnosis, not treatment.
Q. I understand. The issues involved have to do with the diagnosis. But your opinion about the cause of Mrs. Wiley's death --
A. Yes.
Q. -- is not an opinion you have come to or necessarily needed to come to in connection with your treatment of her while she was alive.
MR. CROSS: Asked and answered at least ten times today.
A. Okay.
Q. Do you understand what I'm saying? The process?
A. You're asking me whether my diagnosis and the cause, cause of that diagnosis would have made any difference whether she died or not. That's what you're asking; is that correct?
Q. You didn't need to determine what caused Mrs. Wiley's disease before she died.
A. Did I need to determine that. No.

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Q. It wouldn't have prolonged her life.
A. No.
Q. We're now engaged in an exercise by which we, you, the lawyers and a jury, are going to be asked to try to make that determination. And what I want to know is, when you got involved in that process, and you had to say to yourself, here are the things that could have caused it, here's what I think is the most likely cause of it, how did you go about assuring yourself that Mrs. Wiley wasn't exposed to something other than environmental tobacco smoke that might have caused her lung cancer?
A. Because when I was talking to her, that is the only -- and from my history, as well as from other things that came to me, that they told me during the time that she was on that ward -- and I remember talking to the husband during that time. My God, she was dying, okay? Or she was extremely ill. And I talked to the family members, and I asked, because we had -- I mean, it was, the fact that she presented one way, they had treated her one way, she comes to us, we have to find the diagnosis. And from all of that information, I put that down.
Now, I would not have put secondary to environmental tobacco smoke unless I truly believed that was the diagnosis.
Q. I'm not saying that you don't truthfully believe that. What I want to know, Doctor, is how you went about determining whether there might have been something else that caused it. Or are you telling me that it's a nonsensical question because you didn't -- you didn't need to consider anything else?
A. No, that's not what I'm saying. I'm saying from all the information that was given to me at that time I made that diagnosis.
It's like if somebody has an abdominal aortic aneurysm and ruptures, or has severe peripheral vascular disease and loses a limb, on my history it says I smoke two packs of cigarettes a day or I have diabetes, all of that information is put there and I'll put on the death certificate and I'll put on the death summary that this patient had a ruptured abdominal aneurysm from this cause.

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Q. But my question to you, Doctor, is how did you go about investigating whether the information that was available to you was complete and was accurate or contained a sufficient amount of information about other things she might have been exposed to that could have caused the cancer?
A. I discussed it with her husband, I discussed it with her, and it's right here. Now, I'm not a private investigator.
Q. Here?
A. In the H&P.
Q. Exhibit 14.
A. I am not a private investigator, I did not check on the truthfulness of what they gave me. When somebody comes to me and I'm discussing things and we're going through the differential diagnosis, you know, these are intelligent people.
Q. Well, you wouldn't disagree with me, would you, Doctor, that there are facts that could be proved or brought to your attention about Mrs. Wiley that might have an effect on your opinion about the cause of her disease.
A. You say there are facts.

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Q. Well, are you telling me that there's --
A. I don't know. I don't know. You'll have to bring it to me.
Q. Well, how about facts about the duration or the intensity of her exposure?
A. If you bring that to me.
Q. Could they have an effect on your opinion?
A. The intensity or duration to the exposure to environmental tobacco smoke.
Q. Sure.
A. You're asking the same question in a different way. You're looking at level of exposure. There's no safe exposure level for environmental tobacco smoke. Right?
Q. Well, that's what you're telling me, Doctor. So what you're telling me is you don't need to know -- that nothing I could tell you about the duration or the intensity or the frequency or the efforts Mrs. Wiley made to avoid exposure to environmental tobacco smoke would change your opinion about the cause of her lung cancer?
A. I'm saying from the history that I got, from her, that's my diagnosis.
Q. I understand what you're saying, Doctor.

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Can you answer the question I asked you?
A. You're asking me, if you ask -- if you give me additional information of exposure and duration, would that make a difference. I don't know. I'd have to hear the information. And I would have, you know, we would -- we would have to look at all of the information.
Q. What about if I gave you information about Mrs. Wiley's exposure to other class A or group A carcinogens? Would that have an effect on your opinion about the cause of her disease?
A. You'd have to look at the exposure and whether there's other factors involved.
Q. And am I correct, though, that that exercise, developing those facts, looking at those facts, comparing them to the medical or scientific literature is not an exercise that you've engaged in as it relates to anything except environmental tobacco smoke as it relates to Mrs. Wiley.
A. I don't think that's true. I looked at the history, and, I mean, looking --
Q. The history being what you've described --

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A. H&P, as well as whatever --
Q. -- as Exhibit 14.
A. 14. And what they told me during my -- during the hospital time. And when we decided -- and when I was called for this case to verify whether this is, indeed, if I was still standing by my diagnosis, and whether there was independent observers looking at all the facts, I mean, even looking at the slides and having the pathologist look, that diagnosis, there was no other conclusion that we could come to.
Q. And that verification didn't occur in connection with any quality control program at the hospital; right? It occurred in connection --
A. Not that I'm aware of.
Q. It occurred in connection with a lawsuit or a claim made by Mr. Wiley about the cause of his wife's cancer.
A. It came after I was requested to look at the case and to see if it would still be consistent with that. And I believe it was. And the other individuals that looked at the case, looked at all the data, agreed with

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that.
Q. And you don't know whether those individuals got all the data, do you, about her exposure to other potential carcinogens?
A. I can't tell you that. You'll have to ask them.
MR. OHLEMEYER: Let me pass the witness and take a look at my notes.
MR. CROSS: Let's take a few minutes off the record.
(A recess was taken.)
DIRECT EXAMINATION CONTINUING
BY MR. FURR:
Q. Dr. Turner, my name is Jeff Furr, I'm going to ask a few questions, I'll be as brief as I can so you get done tonight.
Let's start with, are you familiar with how many new cases of lung cancer in nonsmokers occur annually in this country?
A. I believe it's approximately 3,000. Are you talking about nonsmokers?
Q. New cases of lung cancer in nonsmokers in the U.S. population on an annual basis.
A. That are exposed to secondhand smoke, no.
Q. No, just exactly the question I asked.

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Total.
A. I do not know the exact number, no.
Q. If Dr. Burns testified that that number is somewhere between 15- and 20,000, would you have any reason to disagree with that?
A. If Dr. Burns stated that, that's his statement.
Q. And my question is, would you have any reason to disagree with that?
A. If that is, indeed, his statement, then -- I mean, you know, if that's what you're saying, if, you know, Dr. Burns was sitting here and he stated that I would believe him if that was his statement. I mean from his knowledge.
Q. But you simply aren't familiar with those statistics, I take it.
A. No.
Q. What are the causes of lung cancer among nonsmokers?
A. It can have to do with secondhand smoke, it can have to do with, as this gentleman stated, radon. It could have to do with some other type of -- I mean, there's -- those are the primary causes. There may be

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other environmental.
Q. And when you say "other environmental" can you be any more specific?
A. No.
Q. You can't. A number of times today you said you thought there were 4,000 annual cases of lung cancer among nonsmokers attributable to environmental tobacco smoke; is that right?
A. That is the statistics.
Q. Where do you get that statistic from?
A. From the Environmental Protection Agency.
Q. Are you sure it's not 3,000?
A. No, I believe it's 3- to 4,000.
Q. Okay. When is the last time you looked at that?
A. At noon.
Q. And how many cases -- you said there were about 4,000 cases of radon-induced lung cancer in nonsmokers each year; right?
A. Yes.
Q. But you don't know, besides those cases that you would attribute to either environmental tobacco smoke or radon, you don't know the number of lung, additional lung cancer cases that occur annually in the U.S. in

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nonsmokers; is that right?
A. I don't know the exact numbers.
Q. Do you have an estimation?
A. No.
Q. As I've listened to your testimony, you seem to be attaching some special significance to your opinion that Mrs. Wiley had an endobronchial adenocarcinoma as opposed to an adenocarcinoma in the periphery of her lung; is that correct?
A. There is some -- is that what you're asking, is there some significance, the fact that it was an endobronchial lesion versus a peripheral lesion?
Q. In your opinion, yes.
A. Yes.
Q. Why is that?
A. I thought it was very odd that a patient that would have an endobronchial lesion, that was that apparent, it was not a mounding, it was a definite endobronchial lesion that was obstructing that bronchus intermedius.
Q. But why, what significance does that finding have for the etiology of that tumor?

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A. That may indicate, and I felt that it indicated, with the history that she had of environmental tobacco smoke, that -- and as you can note on my bronchoscopy note, on one of them, I believe it was on the 6th, that -- no, it was on the -- yes, I believe the 6th, that my concern was squamous cell carcinoma because of the presentation.
Q. But my question goes to the etiology and what the significance of the tumor in your opinion was with respect to the etiology.
A. The tumor, the presentation? The fact that it was an endobronchial lesion, the fact that, with her history that I obtained when she was admitted, that that was, again, I felt very strongly that it was -- that would increase the chance, certainly, and diagnostic of an endobronchial lesion related to environmental tobacco smoke.
Q. What scientific data are you aware of that suggests that tumors in the endobronchus are more related to environmental tobacco smoke than, say, adenocarcinomas in the periphery of the lung?
A. I can't tell you that. The fact that I do

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know that -- I can't tell you that. You mean will environmental tobacco smoke more likely be endobronchial versus peripheral; is that what your question is?
Q. No. I understand that, you keep using the word feel, that you feel that the fact that in your opinion the tumor was in the endobronchus has some significance for the etiology.
A. I felt that with her history of being heavy exposure and, as they told me, when the husband was telling me that she was working in a haze most of the time, that it increased strongly my suspicions that this was related to environmental tobacco smoke.
Q. Doctor, I'm not going to interrupt you. You can keep answering that way as long as you want to, but I will keep asking questions. I mean, I don't know quite how to convey to you what I'm asking.
I'm not asking about any factor other than the location of the tumor in her lung, in your opinion, the fact that it was in the endobronchus versus the periphery. I'm not asking you about what you think how much

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smoke she was exposed to, or how hazy you think her work environment was.
I'm asking you, because I haven't understood this yet, do you attach significance with respect to the etiology of the tumor to the location of the tumor in the endobronchus?
A. You're asking can environmental tobacco smoke cause a peripheral lesion. Is that what you're asking?
Q. No. I'm asking exactly the question.
MR. FURR: Would you please read my question back.
(The requested material was read back by the reporter.)
Q. You want me to try again, Doctor? You think --
A. No. The answer is, is that I was not suspecting, until I looked down there, that this patient had an endobronchial lesion.
The answer to your question is, is that -- is the fact that she had an endobronchial lesion the reason I called it environmental tobacco smoke? No. The reason -- am I not answering your question?

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Q. Almost. Not the reason. Is it a reason that you called it as related to environmental tobacco smoke.
A. Is it a reason. I would suspect, from the presentation of that patient, it would go along with the diagnosis of inhaled, some type of inhaled toxin.
Q. Okay. And my next question was, could you point me to any scientific literature that suggests that inhaling environmental tobacco smoke is associated with adenocarcinomas in the bronchus.
A. I can't pull them directly towards you. I do know that adenocarcinoma is the -- I mean, if you look at all the differentials of lung cancers related to environmental tobacco smoke, I believe the prominent one is adenocarcinoma.
Now, from what I've read, I do not believe that they define, I mean, where the most likely -- or where they are most likely found.
Q. I think you're right, and so what I'm trying to understand is, every time Mr. Ohlemeyer has asked you to explain the basis for your

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determination that the tumor was attributable to her tobacco smoke exposure, you've listed a number of factors for him, and I appreciate that you look at it all in the totality in your opinion. I'm trying to break them out one at a time to see which ones mean what to you.
And as I understand what you're saying now, when you're describing it as an endobronchial lesion, you're simply describing the location of the tumor and you're not attaching any etiologic significance to the fact that that's where you believe it originated; is that correct?
A. I'm not attaching any etiological significance to that's where it originated; is that the question?
Q. Yes.
A. Not attaching any etiological relationship that's where it originated.
Well, if a tumor is sitting in the airway, and the lady had a right middle lobe syndrome, which is in the history, therefore, she had partial collapse of her right middle lobe, then, I mean, the chances

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are -- I mean, it would seem to me, I would surmise, that most likely that probably originated there or close to there, yes.
Q. Let me try to get at it another way.
If you had formed the opinion that her adenocarcinoma had originated in the periphery of the lung, would that have made you any more or less likely to attribute it to environmental tobacco smoke exposure?
A. I would still attribute it to environmental tobacco smoke because of her history.
Q. Okay, that's what I wanted to know.
Dr. Turner, again, as I've listened to your testimony over the past day, you don't really consider yourself to be an expert on environmental tobacco smoke, do you?
A. I have read a number of articles, I correlate those with my patients, and I've tried to be as familiar as I can with the articles that are out there.
Am I an expert? Am I a research scientist? I'm not a research scientist. I'm a clinician. I treat patients at the bedside. I help make the diagnoses. I try to get them treatment. I try to save their

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lives. Or at least palliate them.
Q. Okay. That's fair.
These articles that you've read on environmental tobacco smoke, what topics have they addressed?
A. They have to do with asthma; it has to do with childhood illnesses; it has to do with heart attacks; it has to do with heart disease; it has to do with cancer.
Q. Okay. Let me ask it a different way. What scientific disciplines have these articles that you read dealt with? And what I mean by that, were they epidemiologic articles or toxicology articles or chemistry or exposure or some combination of all of that?
A. Toxicology, scientific, clinical presentation. I mean, probably kind of across the gamut.
Q. Okay.
A. I mean, I have to look at the article and then -- I'm trying to answer your questions. I'd have to look at each article and say, well, this deals more with toxicology, this deals more with clinical presentation, these are studies.

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Q. Okay. Let's talk about these scientific disciplines and the articles from those disciplines related to ETS one at a time. Let's start with epidemiology.
You've told us you're not an epidemiologist; is that correct?
A. That's correct.
Q. Have you actually systematically identified, retrieved, and reviewed the epidemiologic studies of lung cancer in nonsmokers, the original epidemiologic studies versus review articles written by others?
A. Well, given the fact I've reviewed a number of articles, I have most likely read some of the original articles, such as 1981. I have read some of the most recent articles. You know, without them in front of me --
Q. Well, but I'm not asking you about specific ones yet. I'm asking you whether you've actually taken the step of rigorously reviewing all of the literature that you could identify. Have you taken a step of saying I want to know what the totality of the epidemiologic evidence looks like for myself, and gone out and found all those

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articles and reviewed them using standard epidemiologic criteria?
A. I've looked at epidemiologic studies and tried to look at what the preponderance of evidence was, what those epidemiologic studies show.
Q. And did you do that by retrieving the original epidemiologic articles?
A. The original epidemiological articles. You're talking about the ones that are published?
Q. Yeah. I really, I'm at a loss, I don't think this is -- I'm making this a lot harder than it should be.
I want to know whether you've -- does the term "original" article have a meaning, any meaning to you?
A. You're talking about the one -- the article that was published at the time the data came out.
Q. As opposed to a review article, for instance. Is that a distinction that you can draw in your mind?
A. A review article means to me that someone was reviewing that article as well as

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possibly comparing it to other articles.
Q. Right.
A. The original epidemiologic studies, they did the study themselves, those authors conducted a study themselves.
Q. That's exactly what I mean when I use those terms.
And my question is, have you gone out and obtained and reviewed the original epidemiologic studies of lung cancer in nonsmokers?
A. I have reviewed, again, my memory, I have reviewed epidemiological studies that were conducted by the researchers.
Q. Okay. But did you -- it's obvious that your testimony is that you've reviewed some of them. Have you attempted, in some systematic scientific fashion, to determine whether or not you reviewed them all so that you would know what the total epidemiologic evidence looks like?
A. Well, let me tell you, I have reviewed as many articles as I can find over the last -- since 1984, and probably before that. Now --

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Q. Are you fairly familiar with those studies then?
A. Well, there's been a number of articles with a number of authors and I don't have them in front of me, but I have read -- now, it doesn't mean that I've read them in the last one week, but I have read a number of articles over the last -- since 1984, or before, having to do with these subjects, primary or secondary smoke.
Q. What I'm trying to understand is how familiar you are with those articles and the data reported in those articles as you sit here today.
How many of those articles -- can you even name for me the first investigator, for instance?
A. I think it's an unfair question. I mean, with all the literature that's out there, I think that's an unfair question.
Q. Well, go ahead and answer it anyway.
A. I don't have an answer for you. I think it's an unfair question. I mean, there's a number of articles with a number of authors. And the point is, what you're asking me is,

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if I can't remember the author, then I haven't reviewed the literature. And that's essentially what you're insinuating and that's not what --
Q. We can all draw what inferences we want to. I'm just asking you whether you can do it or not.
A. Well, so what you're saying, if I can't remember the author, then, obviously, I don't know what that article stated.
Q. Can you --
A. Is that right?
Q. No. And I'm not here to answer your questions today, frankly, I'd like for you to answer mine. Unless it deals with a clarification of my question, I'll be glad to try to help you out.
A. Okay. If you would like me to go get the articles I can sit here and I can look at the author and I could, you know, summarize those articles for you.
Q. As you sit here now how many of them can you name for me?
A. Well, there's the gentleman in 1981.
Q. Now you're looking at your notes --

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A. Hirayama.
Q. -- that you gave us today.
A. Yes. Yes. And Trichopoulos.
Q. Hirayama and Trichopoulos.
A. Yes.
Q. Any others?
A. I believe Glantz did some. I mean, there's a number of articles that have been done. U.S. Surgeons General has a number of bibliography -- a series of bibliography articles that can be quoted. But just because I don't know the author doesn't mean that I have not reviewed that information.
Q. Okay. Let me ask you about Glantz. A number of times today you have cited Stanley Glantz as a source of information that you relied upon; is that correct?
A. A few times today.
Q. Who is Stan Glantz?
A. He's a professor I believe at the University of Southern California.
Q. Is he a medical doctor?
A. I believe he's a Ph.D.
Q. In what --
A. I might be mistaken.

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Q.-- do you know?
A.I don't know his exact Ph.D. I believe it's in biochemistry. I believe it's in biochemistry, but I'm not -- I can't tell you for sure.
Q.Go back to the literature on environmental tobacco smoke. Have you ever attempted to systematically identify, retrieve, and review the toxicology studies of environmental tobacco smoke that are relevant to lung cancer risk?
A.I've reviewed some literature on that subject, yes.
Q.What have you reviewed?
A.Well, there was articles that were brought out by the U.S. Surgeons General in their reports, I believe in 1984, if I'm not mistaken. And there was some other information, I believe it was from Stan Glantz, I think he -- I was looking into this subject and I talked to him, I talked to Dr. Glantz, and I believe he sent me some articles. So is that what you're asking?
Q.Well, no, I probably didn't ask you specifically enough. What I meant is, have

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you ever gone out and gotten the primary literature from the toxicology studies of environmental tobacco smoke that would be relevant to lung cancer risk and reviewed them?
A.Primary literature which means they -- the primary literature --
Q.As we defined it earlier.
A.So that would not include the U.S. Surgeon General's Report; correct?
Q.That's correct.
A.Okay. The primary literature. It may not -- I may have and it's been a number of years.
Q.Okay. What about, same type of question only this time with respect to the studies of environmental tobacco smoke chemistry: have you ever gone out and reviewed the original work in that area?
A.The biochemistry of environmental tobacco smoke?
Q.No, the chemistry.
A.The chemistry of environmental tobacco smoke.
Q.Right.

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A.That has to do with -- what's the difference between that and toxicology?
Q.Well, Doctor, do you know the difference between toxicology and chemistry?
A.Chemistry means the chemicals that are involved. Toxicology means the effect on the tissue and how that affects the tissue.
Q.Okay. Sounds like reasonable definitions to me. Let's use those.
A.Okay.
Q.Have you obtained and reviewed the original chemistry studies of environmental tobacco smoke?
A.What is in environmental tobacco smoke?
Q.The chemistry studies as you just defined them.
A.I may have, you know, earlier on, several years ago. I'm sure I have, in fact, because I've given lectures on this subject to the public and so, therefore, I have.
Q.Okay. Let's talk about those chemistry studies then. Maybe this is a blend of the chemistry and other types of studies.
A number of times today in response to Mr. Ohlemeyer's questions you stated that

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you believed that there were, I think the figure you used most often was approximately 50 carcinogens in environmental tobacco smoke; is that right?
A.Yes. Yes.
Q.When you say that, what does the word "carcinogen" mean?
A.Carcinogen means that that chemical, by itself, or with another co-carcinogen, can cause cancer.
Q.Can cause cancer or has been demonstrated to cause cancer?
A.Has been demonstrated to cause cancer.
Q.In humans or animals?
A.Well, most -- I would not think it would be ethical to have a human inhale specifically a specific organism, and that would be the only thing it would inhale and see if that caused cancer; I think that would probably be unethical. I would suspect that some of the original studies were done on animals.
However, the fact is, is that, as we know, primary smoke does cause lung cancer and, after investigation, has been found that that primary smoke does contain those

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chemicals and, therefore, the -- I don't know what the right term is -- they have felt that the cigarette smoke was the cause of the primary lung cancer.
Q. Let me ask you the question this way, then: How many of the chemicals in environmental tobacco smoke have been identified by an authoritative body as human carcinogens?
A. I believe it's over 40.
Q. Over 40. You and Mr. Ohlemeyer also talked for some length of time about relative risk and epidemiologic topics. A few questions in this area that I want to follow up on.
What is your interpretation of a relative risk of 1.3?
A. My interpretation --
Q. As the central estimate.
A. My interpretation of a 1.3, according to what I've understood, is that there is a risk of about a 30 percent increased risk of lung cancer.
Q. 30 percent increased risk above the base line experienced by the general population.
A. Which is 1.
Q. Is that correct?

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A. Yes.
Q. At one point in your answer you began drawing in an analogy for Mr. Ohlemeyer and you started talking about, I think a gun with three chambers in it and putting a bullet in one. What was that all about? What did you mean by that?
A. I meant that the fact that if you have one out of three bullets, and that's a 30 percent risk of getting hit by that bullet, that that, to me, that would increase your risk by 30 percent.
Q. Well, but those are two very different statistical concepts, aren't they? The concept of a 30 percent risk versus a 1.3 relative risk?
A. 1.3 relative risk versus -- 1.3 relative risk to me means that there's a 30 percent or increased risk over base line of developing lung cancer. That's 30 percent.
Q. All right. Without regard to whether or not a person is exposed to environmental tobacco smoke, what is the likelihood that a nonsmoker in the United States will develop lung cancer during their lifetime?

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A. I believe that 10 percent of lung cancers occur in nonsmokers.
Q. Okay. Can you answer the question I asked, though?
A. You asked is --
Q. What's the likelihood that a U.S. nonsmoker will develop lung cancer at some point during their lifetime?
A. And they're not exposed to secondhand smoke, they're not exposed --
Q. I said without regard, talking about for the whole population, including those people that are exposed and those people that aren't exposed to ETS, just on a statistical basis for the U.S. population, what's the likelihood that someone, that a nonsmoker will develop lung cancer at some point during their lifetime?
A. I don't think -- I think what you're doing is trying to --
Q. Ask a question.
A. In my -- I know you're asking a question. I'm trying to answer it, believe me.
In my -- in my experience -- not my experience. In my opinion, and what I

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understand is, and from what your question is, you're kind of mixing everybody. I believe the statistics say that 10 percent of nonsmokers will develop lung cancer. Now, from that point of view, if you're exposed to secondhand smoke, your risk is 30 percent higher to develop lung cancer. You see my point?
Q. Yes. Let me make sure I understand you. You just -- did you just testify that 10 percent of nonsmokers develop lung cancer?
A. That's the statistics. That's my understanding, yes.
Q. So is it your understanding that one out of ten nonsmokers in the United States will develop lung cancer at some point during their lifetime?
A. That's the statistics, my understanding. Now, an epidemiologist would be much more likely to be able to, you know, answer that.
Q. Let's, for the purpose of my next question only, let's assume you're right about that. If that's the case, that an average person has a one in ten chance of developing lung cancer -- average nonsmoker has a one in ten

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chance of developing lung cancer at some time during their life, if they are exposed to an exposure of environmental tobacco smoke --
A. Let's rephrase the question. 10 percent of lung cancers occur in nonsmokers. Okay?
Q. Well, that's a very different -- that's very different testimony than what you gave to me.
A. Than what you just said.
Q. Than what you said.
A. 10 percent of lung cancers occur in nonsmokers. Not one in ten people that are nonsmokers will develop lung cancer. 10 percent of lung cancers. 90 percent of lung cancer are related to tobacco smoke.
Q. All right. Let me reask my original question then, Doctor. If you don't know, it's fine, just tell us. Are you familiar with the incidence of lung cancer among nonsmokers in the U.S.?
A. You're talking about people that are not exposed to --
Q. Without regard to exposure.
A. I don't have the answer to that. I don't

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want to be quick -- you know, tricked into answering a question. I want to make sure I answer the question so that it does not get turned around.
Q. Well, do you feel as though anyone is trying to trick you here today?
A. Yes.
Q. Who is that?
A. I mean (indicating). Let's go on.
Q. Well, have I done something that makes you think I'm trying to trick you, Doctor?
A. Let's just go on.
MR. OHLEMEYER: Well, I think Mr. Furr is entitled to an answer to the question, because I'm, frankly, entitled to an answer to the same question, Doctor.
THE WITNESS: I think when you ask a question 10 times or 15 times in different ways, and -- I'm not trying to change -- I'm not trying to tell an untruth. I'm not trying to tell a lie. I'm trying to tell what I believe is the best answer that I believe from the history and from the evidence that is in this case. But when you ask a question 10 times, but just change an

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adverb or an adjective --
MR. OHLEMEYER: Doctor, I don't want to interrupt but you haven't been shy, nor have your attorneys, about pointing out questions that you didn't understand or wanted to be rephrased, you couldn't answer; isn't that right?
MR. YOUNG: Well, I guess I'll object. She's giving you an answer to the question.
MR. OHLEMEYER: I want the record to be very clear, counsel. I don't mean to interrupt, but I want the doctor to tell us --
MR. YOUNG: Let me just finish before you say your piece and then you'll have ample time. I think she's given you an answer as to why she felt she was being tricked, and this is just getting into an area where we're just arguing back and forth whether she is or isn't; she has her opinion and you have yours.
MR. OHLEMEYER: Well, counsel, it's a very serious charge.
And Doctor, I want to make sure the

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record is very clear that you've been asked to let me know whether or if you didn't understand the question I've asked you. Haven't I asked you that?
THE WITNESS: Yes.
MR. OHLEMEYER: And you certainly have had an opportunity to let me know at any point in time whether you did or didn't understand the question I asked you; right?
THE WITNESS: Yes.
MR. OHLEMEYER: You had an opportunity to ask the court reporter to read back questions and answers at various points in the day; isn't that right?
THE WITNESS: Yes.
MR. OHLEMEYER: All right. Thank you, Doctor.
THE WITNESS: But, again, the point is, is when you ask a question 10 times, you act like I'm trying to lie to you. And believe me, I'm not trying to lie to you.
MR. OHLEMEYER: Doctor, have I suggested to you at any point in time today that I thought you were lying to me?
THE WITNESS: It would appear to

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me. when somebody asks a question 10 or 12 times. with different adverbs, different adjectives. rephrasing the same question. that. you know, you want me to change my testimony or get mixed up or forget what I'm saying.

MR. FURR: Let's not waste any more time on this.

THE WITNESS: Okay. I'm just answering your question.

Q. Okay, Doctor, do you have Exhibit 22 down there which you've told us are a compilation of notes you've made over the past week?

A. Yes.

Q. What was the purpose of your making these notes?

A. To try to summarize a series of articles that I obtained.

Q. Okay.

A. Well. not really. Well. yes. Go ahead.

Q. Okay. To try to summarize a series of articles you obtained. How did you decide to obtain those articles and why did you obtain them?

A. Well. I had reviewed the other articles that

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were there and I have a series of updated articles that are sent by the Society of Critical Care Medicine. it has to do with pulmonary and critical care medicine. and it's updated. and I decided I would want to try to get the most recent information that I could find. as well as the other information that I had there. to prepare for this deposition.

Q. Okay. Let me ask you about a few entries in these notes. if I could. And let's start on page 1. Would you read to us the last three lines on the first page of your notes.

A. "Radon - 222 - a noble gas, is produced in the decay of naturally occurring uranium 238. Source - gas in soil that penetrates into homes."

Q. And what's the significance of this entry in your notes?

A. Exactly what it says. to describe radon.

Q. Why were you doing that?

A. To prepare for this deposition.

Q. But what made you think you needed to be ready to testify about radon?

A. It was in the articles that I read and I was

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trying to be prepared for this deposition.

Q. You mean it was in articles that you read that related the incidence of lung cancer among nonsmokers to radon exposure?

A. No. Well, okay. The incidence of lung cancer due to radon exposure. That is in the differential.

Q. Okay. And you read it here because you're concerned about the role that radon -- excuse me, you wrote it here because you were concerned about the role that radon may have played in Mrs. Wiley's lung cancer; is that right?

A. No. I wrote it here to try to be prepared for your questions and to review, in my mind -- I had no idea this was going to be. to be entered as an exhibit, so I'm writing down all the things that I -- even the fact that it's 900 degrees centigrade. the fact that -- some of these other notes --

Q. Well, I'm only asking you about the radon note now.

A. Okay. Well, your question is?

Q. Okay. Isn't it a fact, Doctor, that you are concerned about the role that radon exposure

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may have played in Mrs. Wiley's lung cancer?

A. No, I'm not.

Q. Then what was the purpose of this note, Doctor?

A. Because. again, I'm summarizing, I'm reading through this article. all through the article. and I'm putting down things that I thought if you asked me I could explain to you and that would remind me of just notations and thoughts.

Q. What thoughts does this note remind you of?

A. What thoughts does this note remind me of. Radon is a noble gas, it's produced in the decay of naturally occurring uranium 238. It occurs in soil.

Q. It doesn't remind you of anything other than what you wrote down on this page?

A. No.

Q. I must have misunderstood you a moment ago. Would you go to the fourth page of your notes. There's a heading at the top of that page, "Bronchogenic carcinoma"; is that correct?

A. Yes.

Q. I want to go down one, two, three, four, six

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lines. And I believe it reads on that line "ETS 2-3X risk."
A. Uh-huh.
Q. What's that mean?
A. Two to three times the risk of environmental tobacco smoke of lung cancer.
Q. I'm sorry, could you say that again?
A. Two to three times the risk of environmental tobacco smoke causing lung cancer. It increases two to three times the risk.
Q. Wait a minute, Doctor. I thought you told us that the relative risk for ETS exposure is 1.3.
A. 30 percent higher risk. That's in that article that I was quoting in my memory. This article presents it in a different way. It's two to three times the risk of normal for environmental tobacco smoke. I mean, you know. I mean, people present data in different ways.
Q. But two to three times the risk correlates to a relative risk of two to three, doesn't it, Doctor?
A. Two to three times?
Q. Yes.

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A. That means if there was a 10 percent chance. it's been increased to 30 percent chance of environmental tobacco smoke?
Q. No. You told us that describing the risk of environmental tobacco smoke as a relative risk of 1.3 --
A. Which is 30 percent.
Q. Which is 30 percent; right?
A. Above the normal.
Q. Two to three times the risk would be 200 to 300 percent above the normal, wouldn't it, Doctor?
A. No, it's two to three times the normal risk. I take this as --
Q. And that would be 200 to 300 percent of the normal risk.
A. I don't read it as such. I read it as it increases your risk of two to three times the normal risk.
Q. Okay. If my risk is twice the normal risk, wouldn't you agree with me, Doctor, that that means that my risk is 200 percent normal risk?
A. I can't tell you. I really can't.
Q. Why is that?

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A. Because I'm not an epidemiologist.
Q. Do you believe that this mathematical exercise that you and I are going through right now requires epidemiologic expertise?
A. No, I think that it -- when I read two to three times the risk, I mean doubles or triples the risk of lung cancer. Just like ten to 25-fold increase in lung cancers related to smokers.
Q. Okay. Let's go to the next line. Looks to me like I have a markout on this line, maybe two of them. Could you read me the next line on the fourth page?
A. Asbestos? You're talking about the fourth page?
Q. The next line, two lines.
MR. YOUNG: Same page?
MR. FURR: Same page, yes.
A. The next line. 15 to 20 percent of lung cancers in nonsmokers.
Q. What's that mean, Doctor?
A. Well, I'd have to, since I was just writing these notes --
Q. Go ahead, take a look at them.
A. 15 to 20 percent of lung cancers in

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nonsmokers. ETS 15 to 20 percent. That means that environmental tobacco smoke most likely is the cause of 15 to 20 percent of lung cancers in nonsmokers. I mean, I could go back and look at the original article.
Q. No, I'll take it; if that's your understanding, that's fine.
Let's try to turn that around, Doctor. Doesn't that also mean that 75 to 80 percent of the lung cancers in nonsmokers are caused by something other than tobacco smoke?
A. Yes.
Q. So just as a purely statistical matter, if someone tells you I have a nonsmoker with lung cancer, wouldn't you agree, Doctor, that the chances are about three out of four that that lung cancer was caused by something other than environmental tobacco smoke?
A. Depends on the risk factors. What's the risk factors?
Q. I said purely as a statistical matter.
A. You can't do that. I think you have to look at the whole picture. I mean, if somebody told me they had lung cancer, they were a

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nonsmoker, I would immediately say, okay, what are your risk factors? Why did you develop lung cancer?
Q. Okay, Doctor, what are the risk factors to which the 75 to 80 percent of lung cancer cases in nonsmokers, that aren't ETS-related, what are the risk factors that are responsible for the other 75 or 80 percent of the cases?
A. Well, perhaps environmental, perhaps radon, perhaps other things.
Q. Again, I just want to make sure, when you say "perhaps environmental," what do you mean?
A. Environmental. Environmental. Any other environmental -- any other environmental factor that may cause lung cancer, I really can't tell you. I mean, there's other environmental factors that can occur.
Q. Doctor, I don't want you to accuse me of tricking you here so I want you to understand what I'm talking about.
You and Mr. Ohlemeyer had a discussion between 5 and 5:30 today about how you determined that Mrs. Wiley's lung cancer was

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attributable to environmental tobacco smoke, and part of that discussion focused on the process that you went through in ruling out other causes.
Is that a fair characterization, Doctor?
A. We went through -- we went through the reasoning of why I made the diagnosis that I did.
Q. That's right. And wasn't part of that reasoning an exercise in ruling out other potential causes?
A. Yes.
Q. My question to you, that I didn't understand from your discussion with Mr. Ohlemeyer, is how did you go about ruling out the causes -- the causes that account for 75 to 80 percent of the lung cancer in nonsmokers with respect to Mrs. Wiley's case?
A. Again, you know, when you look at a patient, you look at what their presentation is. You look at what's the most likely cause from the history that they give you and the presentation that they give you.
If it makes the most sense and the most

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reason behind that, to diagnose from the exposure that they gave you, that's the diagnosis you give.
Q. Okay. I don't want to go through all that again, but what was it about Mrs. Wiley's presentation that led you to believe that her cancer was caused by environmental tobacco smoke exposure? Not that she had cancer, but that the cancer that she had was caused by environmental tobacco smoke exposure.
A. The cancer that she had was caused by environmental tobacco smoke. Her history.
Q. Wait a minute. You gave me history and presentation as separate factors a moment ago.
A. No, it's not. It's the same.
Q. It's the same factor?
A. You put the patient together, you don't split them apart, the history and presentation. I mean, it's like a puzzle: you fit all the pieces together that make the most sense and the most diagnosis.
The presentation of hers, the fact that the adenocarcinoma, the fact that she had

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heavy inhalation by history of environmental tobacco smoke --
Q. Doctor, I don't want to interrupt but I'm trying to move this along for all of us.
A. Yes.
Q. The question I'm trying to ask now is, I don't want to know about her history now, if we could set that aside. What can you tell me about her presentation and how that aided your effort in determining what the cause of her lung cancer was? Not that it was cancer but the cause of it.
A. Well, it had to do with her presentation.
Q. Yes, ma'am.
A. Her history. And at the time there was nothing else that would make sense in this situation. I'm trying to answer your questions and I can't change the reality.
Q. Doctor, are the words --
A. I mean, I didn't go out and look for this patient. Believe me.
Q. I'm not suggesting -- I haven't suggested here today that you did.
A. And I'm not trying to make things up.
Q. Do the words "presentation" and "history,"

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are those synonymous in your mind?
A. History is the past medical history, history is exposure, history is -- history and physical examination have to do with their family history, has to do with their environment, has to do with their occupation, it has to do with their work history, it has to do with their present illness, and their past medical illness. That's if you look at what the present -- I mean what an H&P is.
Q. That all comes under the term "history"; is that correct, Doctor?
A. Yes.
Q. Now, can you tell us what presentation means?
A. Presentation is, has to do with history as well, what they present you -- how a patient presents to you. If I had a patient in the emergency room that presented to me, I would take their history, plus their examination, plus the x-rays, plus all the data that they presented to me.
Q. I'm having a hard time understanding what presentation means when you use the word

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"presents" to define it. Is there any way you can define it without using the word "presents"?
A. Presentation -- essentially the patient and all the data that occurs with that patient. And all the x-rays.
Q. Let me ask the question this way: If Mrs. Wiley had never said anything to you about environmental tobacco smoke, if no one else ever said anything to you about her having been exposed to environmental tobacco smoke, was there anything about Mrs. Wiley's body, including her lung and the tumor that you think was in her lung, that indicated to you that she had been exposed to environmental tobacco smoke, or that environmental tobacco smoke was the cause of any disease that she had?
A. If -- if this patient could not speak to me and I had no other history available, when I did the bronc I would ask myself, Why does this patient have an endobronchial lesion that is totally obstructing the right bronchus intermedius? Why did she have a right middle lobe syndrome before? Why did

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she have a persistent cough? And why did she have hemoptysis?
Does that answer your question?
Q. No, it doesn't.
A. Okay, I'm sorry.
Q. What would any of that tell you about environmental tobacco smoke?
A. It would not.
Q. Okay. That answered my question.
Let's go to the history now. A number of times today you've told me --
A. Let me go back. The fact that it was an endobronchial lesion makes me concerned that -- and you have to understand, and you can ask any of the other physicians that I've worked with over the last 14 to 18 years that, when I see a patient, I like to have everything fit together. And I like to make sure, as much as possible, that things make sense.
If I saw a lesion in the airway, I would wonder what type of inhalation this patient had to cause an endobronchial lesion. So I wanted to put that in there. I mean, you know, that is -- that, to me, is

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part of the presentation. As well as the fact that she had a right lung mass.
Q. Okay. Tell me if I'm being unfair, Doctor, but the bottom line, from all that you just told us, is that there's nothing about Mrs. Wiley's physical presentation that indicated anything about environmental tobacco smoke and its involvement in her disease.
A. I don't -- I don't -- her physical presentation.
Q. Yes.
A. The fact, again, that this was an endobronchial lesion, that she had been ill for some time. Usually, as I said before, an adenocarcinoma does not -- at least in my experience, I have not diagnosed that as in the airway itself, and that struck me as extremely odd. And you can note that on my bronchoscopy note. I said that -- bronchoscopy note from the 6th of June, suspect squamous cell carcinoma. You know, primary neoplastic process, right main stem with total occlusion of the bronchus intermedius. It was not a lesion that was

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coming up from the outside. It was a lesion in the airway.
So, to me, trying to be as thorough as possible in this situation, and in every patient that I take care of, you try to answer the question of why this patient had this particular lesion.
Q. Okay. My question is, what does any of that tell you, any of those physical findings, what do any of those physical findings tell you about the etiology of her disease?
A. It appears to me that I would be concerned about some type of toxic chronic inhalation that may have been the etiology of her disease.
Q. But it sure wouldn't point to environmental tobacco smoke specifically, would it?
A. I would go back to the patient and her family and I would investigate from there.
Q. You'd have to go outside the physical findings to do that; right?
A. Yes.
Q. Let's go outside the physical findings. Let's go back to the history now. And a number of times today you've told us that,

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based on the history, that you found environmental tobacco smoke to be the most likely etiologic factor relating to her cancer; is that right?
A. Yes.
Q. In fact, Doctor, if 75 to 80 percent of the lung cancers in nonsmokers are related to something other than environmental tobacco smoke, isn't it true it was far more likely to be something else than environmental tobacco smoke that was the cause of her lung cancer?
A. With the presenting factors that she had, and the presenting history, I would still make the same diagnosis. I mean, how else would the 20 to 25 percent or 30 percent exist if the diagnosis was never made?
Q. What's that mean, Doctor? I don't understand.
A. That means that you can't discount -- you can't discount those percentage of patients just because -- that's why we're physicians and that's why we make diagnoses. You can't just say, okay, I just don't believe that -- it's such a small percentage, I'm not even

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going to diagnose that. If that was the case, we would all have the same diagnoses. You understand what I'm saying?
Q. Doctor, isn't it a fact that on a number of occasions today you have discounted factors other than environmental tobacco smoke as being the cause of her disease because they were such small percentages in your mind?
MR. YOUNG: I'll object. We've been over that.
MR. FURR: I've never asked this question before.
MR. YOUNG: The whole day, though, it's been asked and answered and covered for hours and hours, yes.
MR. FURR: No, it hasn't.
Read the question back to the doctor, please.
(The requested material was read back by the reporter.)
MR. YOUNG: Same objection.
A. The point is, is that the presentation is such that that -- I mean, if someone said they walked in and dropped a bowling ball on their foot and then you asked them what

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their -- I mean, it's the same thing. You see my point?
Q. No, Doctor, I don't.
A. You don't see the point. The point is, is that you look at the history, you look at the presentation, you look at what information and what evidence they give you, and you correlate the most likely diagnosis with that evidence and that history and that presentation.
Q. Dr. Turner, did I understand you today to testify that there are six chemicals that have been identified by the EPA as group A carcinogens?
A. Yes.
Q. Is that your understanding?
A. Yes.
Q. Do you have Exhibit 3 handy? I want to take you back to a couple things on Exhibit 3. And let's start with No. 1 at the bottom of the page, which are two sentences that you and Mr. Ohlemeyer talked about some earlier today. Do you recall that?
A. Yes.
Q. The second sentence reads, "If his frame of

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mind at the time was the fact that we were most likely adenocarcinoma, that would help him make a decision about what he could testify to." You see that?
A. Yes.
Q. Now, you wrote that sentence; is that right, Doctor?
A. I dictated that sentence.
Q. You dictated. What does that sentence mean?
A. Well --
MR. YOUNG: I object.
Mr. Ohlemeyer spent quite a bit of time on this and he had lengthy discussion about what that sentence and the other sentence meant and whether or not a third sentence would apply and it's just rehashing what we've been through already.
MR. FURR: Go ahead, Doctor.
A. Which is what I said before.
Q. What is that?
A. When I dictate -- how do I -- I mean, the point is, what you're asking me to do is pull those two sentences together.
Q. I'm just asking you about one sentence, Doctor.

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A. No, no. You're saying if his frame of mind at the time was the fact that we were most likely adenocarcinoma, that would help him make a decision about what he could testify to, the question arises why we didn't start aggressive chemotherapy.
First of all, I think it would behoove you to ask Dr. Songer that question.
Q. Doctor, you wrote these sentences, not Dr. Songer.
A. No, I dictated the sentence. I did not write it. I dictated it.
Q. Now, there's an important distinction.
A. And as you know, sometimes dictations, people --
Q. Is it your testimony this is an inaccurate transcription of your dictation?
A. My testimony is when I dictate -- I can't tell you if words were left out because I -- unless you have the original tape and what I dictated to. I can't tell you if words were left out or not.
Q. This sentence, as it appears on Exhibit 3, does that sentence have any meaning to you?
A. If his frame of mind at the time was the fact that we were most likely, probably most likely dealing with -- likely adenocarcinoma, that would help him make a decision about what we could testify -- what he could testify to.
Again, I think that you should ask Dr. Songer about that because he's the one that would testify to it. Not me.
Q. Okay. Did you dictate that sentence?
A. I dictated that sentence.
Q. What did you mean when you dictated that sentence?
A. Well, you have to go to the top, the sentence before. "We are going to review the chart to see what his frame of mind was and why we didn't start aggressive chemotherapy. If his frame of mind at the time was the fact that we were most likely adenocarcinoma, that would help him make a decision about what he could testify to."
So it would seem to me like -- again, I would recommend that you talk to Dr. Songer, but if this was adenocarcinoma, that may be one reason why he did not start aggressive chemotherapy because there was nothing else

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to do for this lady.
Q. Okay. But how was this reconstruction of his frame of mind, how did you believe that that was going to affect his decision about what he could testify to?
A. How would --
MR. YOUNG: Well, let me -- I want to make an objection because it has been asked and answered.
MR. FURR: It's been asked, it hasn't been answered.
THE WITNESS: I'm trying to answer the question.
MR. YOUNG: Let me talk, will you, Doctor?
THE WITNESS: Yes.
MR. YOUNG: We've been here since 9:00 this morning, it's now 25 till 7, you've been very cordial and very agreeable, took breaks whenever necessary and a lunch break, but still the same, it is a long day and we're continuing to go over the same material that we've gone over at length throughout the course of this entire day. And I think we ought to try and move to

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topics that haven't been covered and not cover those that have been asked and answered repeatedly.

MR. FURR: I agree completely. My opinion is it's been asked a lot of times, it hasn't been answered. That's why I'm trying to ask it again.

A. What would you like me to answer?

Q. I'd like for you to tell me what you meant when you wrote that second sentence.

A. Well, if I knew what I meant -- if I could tell you what that sentence meant, with those two sentences, I would gladly answer you.

Q. You just can't do it; is that --

A. Because I'm not Dr. Songer. And my point is, if his frame of mind at the time was the fact that we were most likely dealing with an adenocarcinoma, that would help him make a decision about what he could testify to; since I am talking about Dr. Songer, then I think that you need to ask him. I don't want to put words in his mouth as well.

Q. Well, I tell you what throws me off, and why I'm having trouble understanding. I thought

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I was with you when you just simply said I don't know what I meant there, but then you threw in you'd have to ask Dr. Songer.

It seems to me that I'm talking to the right deponent now to ask them what this language means in an exhibit that they dictated, so I don't understand how Dr. Songer is in a better position to explain to me what you meant when you dictated these sentences.

Can you help me understand that?

A. Well, it says, If his frame of mind at the time was the fact that we were most likely dealing with -- or likely adenocarcinoma, that would help him make a decision about what he could testify to.

The point, if his frame of mind, it's exactly what it says. If his frame of mind -- I'm not trying to be difficult, believe me. It says, "If his frame of mind at the time was the fact we were most likely adenocarcinoma, that would help him make a decision about what he could testify to." It's his frame of mind. He's the one from an oncologist's standpoint that will

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testify.

The first sentence is, "We are going to review the chart to see what his frame of mind was and why we didn't start aggressive chemotherapy." So what you're trying to do is act like I'm the oncologist. I'm not the oncologist; Dr. Songer is.

Q. You know, Doctor, I'm trying to be very polite. It doesn't help in this process to cast aspersions about my motive.

A. I'm not. I'm not, really.

Q. About this trickery stuff that you've thrown out once already, it doesn't advance this process any.

A. Okay.

Q. I think if I just ask the questions and you just answer them and we don't -- try not to comment on what each other is doing, this will all go a lot better; is that agreeable to you?

A. Yes. I've already told you, though, I cannot answer the question because I am not Dr. Songer. I don't know what else you want me to say.

Q. Let me ask it this way, then: When you

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wrote this sentence --

A. When I dictated this sentence.

Q. When you dictated this sentence, did you have a belief or understanding as to how determining that the tumor was most likely an adenocarcinoma would affect Dr. Songer's decision about what he could testify to?

A. No. I mean, this was 1993, May of '93. That was four years ago.

Q. Okay. Are you telling me now that you didn't have a belief when you dictated this sentence or that, if you did, you simply don't remember?

A. I can tell you what those sentences are. And if it doesn't -- I mean, if I can't think of -- I can't interpret those sentences other than what I've said to you, that's about the best I can do.

Again, I think Dr. Songer -- I wrote that, or dictated that after I spoke to Dr. Songer about the fact that why we didn't start aggressive chemotherapy.

Q. Okay. Let's stay on Exhibit 3 for a minute. Let's go up to the first paragraph. I'm not sure how to pronounce, is it Dr. Kocoshis?

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A. Dr. Kocoshis.
Q. Dr. Kocoshis. In the first paragraph, the sentence says, "I, in turn, checked with Dr. Thomas Kocoshis, and he felt that the tumor from the slides is probably related to lung cancer, but given the elevated CA15-3 possibly breast or pancreas." Do you see that?
A. Yes.
Q. Now, earlier today when Mr. Ohlemeyer asked you about that, I thought I heard you say, or I should say speculate that Dr. Kocoshis' feeling may have been influenced by the fact that he looks at lots of slides and probably gave this review of this slide a fairly brief review and didn't go beyond that. Is that what you said?
A. I said when he was -- when I was asking him about this, his concern was the CA15-3.
Q. Okay. So, in fact, Dr. Kocoshis' concern was not based on the slide, but was based on this CA15-3 titer result that was in the medical record; is that right?
A. That's not what I said. He felt the tumor from the slides is probably related to lung

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cancer, but given the elevated CA15-3, possibly breast or pancreas. He's going through the differential diagnosis from the information that I gave him.
Q. So his reluctance to rule out breast or pancreatic primary cancer was based on the elevated CA15-3; is that right?
A. From the slides I gave to him, at this point in time, in May of '93, two years after her death, from the slides I gave to him, not the autopsy, you know, that's the question. That's what his concern was, the CA15-3.
Q. Okay.
A. At least that's what this note states.
Q. Well, you wrote this note, didn't you?
A. I dictated the note, yes.
Q. So you believed this notation when you dictated it, didn't you?
A. Yes.
Q. And you thought it was accurate to the best of your understanding of his feelings?
A. I dictated what he stated to me.
Q. In the next paragraph there's a reference to a Dr. Triplett. Who is Dr. Triplett?
A. He's a pathologist.

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Q. Do you know him personally or by reputation?
A. I know him. He works here.
Q. What is your opinion of Dr. Triplett's professional skill?
A. My understanding, he's a good pathologist.
Q. Okay. You asked him to review some materials in this case; is that right?
A. Review the slides himself. I asked him to review the slides.
Q. Okay. And your understanding is that he did review the slides?
A. Yes.
Q. And I take it that he also assessed the clinical presentation as well; is that correct?
A. I don't know whether he assessed the clinical presentation. He reviewed the slides.
Q. Okay. Doesn't the next sentence say that "He stated that with the clinical presentation..."?
A. "With the clinical presentation as well as the slides that he had looked at..."
Q. So when you made this notation, or dictated this notation you believed that he had

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reviewed the clinical presentation also, I take it.
A. Yes.
Q. And having done those things, Dr. Triplett believed that there was a 30 percent chance that the primary tumor that Mrs. Wiley had was either breast, bowel, or pancreatic; is that correct?
A. Yes. But in the next sentence it says, "In reviewing the autopsy report, however, the pancreas was normal with the exception of peripancreatic metastatic tissue."
Q. What's that have to do with Dr. Triplett's opinion?
A. Because that's all together there.
Q. That's your effort at explaining away Dr. Triplett's opinion.
A. No, I can't tell you that.
MR. YOUNG: I object. That's argumentative.
A. I'm not saying that. This is a discussion. You can't take one sentence out of the whole thing.
Q. Notwithstanding the rest of this discussion, Dr. Triplett's opinion was that there was a

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30 percent chance that Mrs. Wiley's primary was breast, bowel, or pancreatic tumor; is that right?
A. No, the point is --
MR. YOUNG: I object, that misstates the testimony.
A. I mean, I'm not putting words in here. We had a discussion. He reviewed -- you already said it, he reviewed the clinical presentation; that would include the autopsy report. It states, "In reviewing the autopsy report, however, the pancreas was normal with the exception of peripancreatic metastatic tissue. This would be pretty unusual if they did not find a primary pancreatic tumor inside the pancreas and just not on the peripancreatic lymph nodes. The stomach was looked at and was negative. The bowel was looked at and was negative. A gross evaluation of the breasts was completed with palpation, and this was negative. Therefore, the breasts were not looked at at the time of the autopsy."
Clinical presentation, I mean, from this dictation -- I mean, I'm asking these

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people for their opinion. I mean, we're trying to decide whether this case is, like you said, and other individuals have said, have outside critiques, I was trying to get pathologists and other individuals to look at slides, look at the clinical presentation and independently come up with what they thought. And this is what this is saying.
Q. Okay. I'm just trying to understand, having done all that, and in light of all the considerations that you just read to us, Dr. Triplett's opinion was that there's a 30 percent chance that Mrs. Wiley's cancer was either primary to the breast, bowel, or pancreas.
A. That's not what this said. You have to look at the whole paragraph.
Q. We'll let the jury decide what this says.
A. Well, give the jury the entire paragraph, which is -- I mean, you're picking out sentences. You're taking part of my conversation and picking out whatever you want and you can't do that.
Q. Just more trickery, Doctor.
A. Or you shouldn't do that.

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MR. YOUNG: Let's not argue.
Q. You also have spoke today a couple of times about a Mr. Repace; is that right?
A. I've spoken I believe one or two times, yes.
Q. That's what I said. And you relied upon Mr. Repace as an authoritative source about certain issues related to environmental tobacco smoke; is that right?
A. He wrote several articles I have read. And I believe in one of my notations, I don't know whether I called him or whether -- I'd have to look at the notation again with his name there.
Q. Let's go to Exhibit 19.
A. Okay. "On May 3 I discussed this case with J.L. Repace."
Q. Doctor, in one place here you call him Mr. Repace, in another place you call him Dr. Repace. Do you know which it is?
A. No. I mean I -- I transpose -- no.
Q. Now, beginning with the third paragraph, first sentence in the third paragraph reads: "Dr. Repace did state that he would be able to quantify hopefully the exposure that Mrs. Wiley had to secondhand smoke." Do you

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see that?
A. Yes.
Q. Now, did you, in fact, ask Mr. Repace to quantify her ETS exposure to secondhand smoke?
A. Did I ask?
Q. Yes.
A. I did not.
Q. Do you know whether anyone asked Mr. Repace to quantify Mrs. Wiley's exposure to secondhand smoke?
A. The attorneys may have. I am not aware that they did or did not.
Q. Have you seen anything produced by Mr. Repace or heard anything from the attorneys as to whether Mr. Repace attempted to quantify Mrs. Wiley's exposure to secondhand smoke?
A. I have not heard anything.
Q. A couple of times today you've mentioned what you described as cellular markers of environmental tobacco smoke exposure. You recall mentioning that today?
A. Cellular biochemical markers?
Q. Right. You recall mentioning it?

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A. Yes.
Q. Do you know whether anyone has attempted to determine whether or not tissue from Mrs. Wiley exhibits cellular or biochemical markers that would indicate exposure to secondhand smoke?
A. Okay. Ask the question again. Do you know if what?
MR. YOUNG: I'll object. That's the same area that was covered earlier today; exactly same thing.
MR. FURR: Same area, different question.
Q. Do you know whether any work was done in this area with respect to Mrs. Wiley?
A. I can't tell you for sure, no.
Q. When you say "for sure," do you have some belief as to whether some work was done?
A. I can't tell you because the attorneys have not really told me much about all the other stuff. I don't know who they have talked to. I don't know what all the evidence they have. I don't --
Q. Have they told you -- excuse me, go ahead if you're not finished.

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A. No, go ahead.
Q. Have they told you anything at all about whether these type of studies were being performed with respect to Mrs. Wiley?
A. They have told -- they have not told me for sure that these are done. Just like they haven't told me whether this Dr. Repace did any of the work that -- you know. All I know is what I have here. I mean, we have had very few conversations over the last five years or four years.
Q. I may have misunderstood your testimony earlier today but when you were testifying about the transthoracic biopsy that was performed on Mrs. Wiley, I couldn't tell whether you were saying that that procedure enabled the determination of the cell type of the tumor or the location of the primary tumor. Could you clarify that for me?
A. It confirmed the cell type.
Q. That procedure, in fact, did not provide any evidence about the location of the primary tumor, did it?
A. Well, they went where the money was. They went -- I believe the transthoracic biopsy

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was into the area with the largest mass of tissue, which is what they would do, to decrease the risk of having a collapsed lung or a hemothorax.
Q. But my question is, the results obtained by performing that procedure did not provide any evidence about the source of the primary tumor, did it?
A. The site or the source?
Q. The site of the primary tumor.
A. The site of the primary tumor. Okay, your question is -- it confirmed the fact that we were dealing with an adenocarcinoma.
Q. Okay. Didn't tell you where the adeno, where the primary adeno was, though, did it?
A. It did not tell me -- if a transthoracic biopsy is done on a lung lesion, I mean, it could have been done on a metastatic lesion. The problem is, is that, I mean, you would not want to go for a transthoracic biopsy if there's -- I mean, doing a CT-guided aspiration of an intra-abdominal mass would be much less risky.
It depends on where the tumor is, where we think the primary is, what the risk of

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hitting bowel was, what's the risk of hitting lung. There's a lot of things that enter into that.
Q. Okay, Doctor, I understand that you're testifying that the decision as to performing the transthoracic biopsy was informed by your belief about this primary source of the tumor. I understand that.
A. Yes.
Q. My question is, the results obtained by performing that procedure did not provide any additional evidence about the primary source of the tumor, did it?
A. No.
Q. Okay. Dr. Turner, are you aware of any scientific data that suggests an increased lung cancer risk from environmental tobacco smoke exposure six to eight years after cessation of that exposure?
A. I can't tell you -- you're asking if that -- if there is evidence out there or there was studies out there; is that what you're asking?
MR. FURR: You can read back the question if you want, ma'am.

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(The requested material was read back by the reporter.)
A. I cannot tell you that there is literature out there that looked at epidemiologic studies six to eight years. I would suspect, given the risk involved, that there would still be some increased risk of lung cancer. Have there been epidemiologic studies done? I have not seen them.
Q. That's what I'm asking you. With all due respect, I'm not asking for your suspicion right now.
A. Yes.
Q. I'm asking for your knowledge as to whether such studies exist.
A. I'm not aware. I have not read studies that have specifically noted that. Or studied that population.
MR. FURR: One more thing, I might be done.
MR. OHLEMEYER: Can I ask a couple questions while you're looking, Mr. Furr?
MR. FURR: I don't have any objection, if counsel doesn't.
MR. OHLEMEYER: I just have a

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couple.
DIRECT EXAMINATION CONTINUING
BY MR. OHLEMEYER:
Q. Dr. Turner, did you attend Mrs. Wiley's funeral?
A. No.
Q. Did you attend the visitation?
A. No.
Q. How and when did you obtain her obituary?
A. Oftentimes the individuals, the office staff will cut obituaries out and put in the chart.
Q. I don't -- this may be unfair to your other patients. I'm sure you feel the same way about all of them, but do you have patients you feel more affinity for or interest in?
A. Depends on -- I mean, I have patients that I've been caring for for 15 years. It has to do with the patient and -- I mean, I've had patients, trauma patients that I've cared for for three months. I mean, you know.
Q. I understand. With respect to Mrs. Wiley, though, because she was a nurse, she was connected to your profession in some way,

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did you feel any special affinity for her or have any special interest in her case?
A. I felt sorry for her. I felt she was in a lot of pain. And I wanted to relieve that pain. Did I -- special affinity. I mean, what does that mean? That I sent them letters of condolences or --
Q. Well, did you do that?
A. No.
Q. Was Mrs. Wiley's case a frustrating case for you as these cases -- I mean, I realize everything you deal with is difficult, but was it particularly frustrating?
MR. YOUNG: Well, I'll object, it's vague.
THE WITNESS: Do you want me to answer the question?
MR. OHLEMEYER: Sure.
THE WITNESS: I don't know why you object if I have to answer the question.
MR. YOUNG: I object, that's okay, you need to continue to answer the question.
THE WITNESS: I'm glad you object, though.
A. Was it a frustrating case? In the fact that

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she was in a lot of pain, yes. Is it any more frustrating than hundreds of other cases that I have taken care of? No.
Q. Exhibit 6 previously marked in your earlier session deals with a meeting with Sanford and Bernstein about your retirement fund.
A. Oh, yeah. I was making notes on the back of that.
Q. What do the notes pertain to?
A. Well, these are data from tobacco farmers in Indiana, I believe, and I believe maybe parts of Ohio -- Kentucky.
Q. I mean, what data? Why? What interest do you have in all of that?
A. I was named to the Tobacco Task Force about two years ago by the Indiana State Medical Association, because of my interest in education of children and my interest in this subject. There are five other physicians across the state that were named to that. I have no idea why I was named to that except I was told by the president of the Indiana State Medical Association, they asked me if I would do that. And we were discussing tobacco farmers and how to,

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hopefully, improve their lot. That's all.
Q. Do you think people who grow tobacco bear any responsibility for the health risks associated with the purchase and use of tobacco products?
MR. YOUNG: Well, I'll object, that's outside the issues of the case and it's irrelevant.
A. I think that -- do they bear responsibility? I do not believe that. I think that they have farmland that is often not used for other crops and that they are paid highly by the tobacco industry to grow that tobacco. And I believe that they are victims just like smokers are victims or secondhand smoke exposure are victims.
Q. What are they victims of?
A. The tobacco industry. Of having a product that is addictive and that they sell.
Q. The people who --
A. That causes harm.
Q. The people who grow tobacco, in your opinion, are victims of the tobacco industry.
A. Yes.

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Q. Are the people who sell tobacco in retail stores victims of the tobacco industry?
A. Are store owners?
Q. Victims of the tobacco industry.
A. I think they make a decision about whether to sell it or not. And because it is a lucrative -- they are trying to run a business and, therefore, they sell it.
Q. Does that make them victims? Or are people -- let me ask a better question. Are people who make choices victims of those choices?
A. I think it has to do with the circumstances.
Q. All right. One other question, Doctor. Do you have any -- have you ever examined your retirement account to see if there's any tobacco stocks in it?
A. There was at one time. And I sold it all.
Q. Sold it all.
A. Yes.
Q. So when did you do that?
A. At a loss.
Q. When did you do that?
A. Couple years ago, I believe. Several years ago, in fact. I don't know. I don't know.

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You'll have to ask Mr. Bernstein in New York.
Q. Was it before or after you got involved with Mrs. Wiley's treatment and care?
A. Well, the problem --
MR. YOUNG: Well, I'll object, that's totally irrelevant.
Q. It's my last question, Doctor.
MR. YOUNG: Intervening with her private affairs.
Q. The sooner you answer it, the sooner I'm finished. When did you make a decision to divest yourself of your tobacco stocks?
A. Well, the problem is, I was unaware they had invested.
Q. When did you make the decision to divest yourself of the stock that other people had purchased on your account?
A. It was after this occurred. I was told -- and I had asked them on a number of occasions to sell the stock, and they had told me on a number of occasions why don't you use the money to do other projects and things like that.
Q. I don't want to interrupt you, you say

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"after this occurred"; what do you mean? After what occurred?
A. After this occurred.
Q. "This" being what?
A. After this occurred. I made the decision to sell, and finally they listened to me because I kept calling them and saying sell.
Q. When did you start calling them and telling them to sell?
A. Oh, a long time ago.
Q. Well, give me a sense of when it was.
A. Probably in the '80s right after I found out that they had invested, they had invested across the board.
Q. That answered my question. Thank you, Doctor, you've been very patient.
MR. FURR: Just a few more, Doctor.
DIRECT EXAMINATION CONTINUING
BY MR. FURR:
Q. Okay, Dr. Turner, today on at least two times, by my count, when you and Mr. Ohlemeyer were discussing the likelihood that environmental tobacco smoke would increase an individual's lung cancer risk you identified factors that you would have

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to look at to include the duration, the intensity and the frequency of that exposure, and the genetic makeup of that individual. You recall that?
A. Okay. Your question is -- do the question again, please.
MR. FURR: Could you just read it back, please, ma'am.
(The requested material was read back by the reporter.)
A. Your question is, is whether I -- I'm sorry.
Q. My question is whether you recall having that discussion with Mr. Ohlemeyer.
A. We've had so much discussion today I'm really trying to focus on your question. Would you please -- it didn't make sense when she read it back. Would you please do it again.
Q. I'll try to ask a different way.
Is it your opinion that the genetic makeup of an individual can affect their susceptibility to having disease induced by environmental tobacco smoke exposure?
A. I am not an epidemiologist. I'm not a biochemist. I'm not a geneticist. I do

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not -- I cannot tell you for certain that -- I mean, I would think that part -- there may be some risk but I can't tell you percentages. And I can't tell you whether -- I mean, if -- I've not heard of a family series -- you know, colon cancer, if somebody has familial polyposis, that family has a risk of colon cancer. It's very high; almost 100 percent, I believe. Or 90 to 100 percent. If a family has a history of breast cancer, I cannot tell you the same for lung cancer.
Q. Was there anything about Mrs. Wiley's genetic makeup that made her especially susceptible to having lung cancer induced by environmental tobacco smoke exposure?
A. I can't tell you that that --
Q. If you can't, that's fine.
A. I can't.
Q. Did you follow the flight attendant ETS class action case in Florida known as the Broin case?
A. I read a couple of articles in the paper. Whatever, you know, I may have read --
Q. Were you interested in that case?

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A. Yes.
Q. Why is that?
A. I'm interested in the fact that -- the litigation against the tobacco industry; that's all.
Q. So your interest in the Broin case was just a part of your general interest in litigation against the tobacco industry; is that correct?
A. My interest in the Broin case is the fact that -- I mean, I've read about other cases as well, and probably I read more -- no more than maybe three to four articles about the whole case. So I don't even -- I'm just interested. And I read a lot of literature, as much as I can find, about the tobacco industry.
Q. What is the nature of your interest in tobacco litigation?
A. What is the nature of my interest in the tobacco litigation. It's probably no more than my interest in tobacco and the fact that states are trying to get advertising down and other things. It's just a culmination of all the information regarding

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the industry.
Q. Do you have a hope that, in general, plaintiffs will prevail in their litigation against the tobacco industry?
A. Plaintiffs means the people that have been hurt?
Q. Including states and individuals.
A. I'm not a lawyer, so plaintiffs mean the people that have been hurt?
Q. The people that initiate the lawsuits and are seeking money from the tobacco companies.
A. If -- if their case is such that the tobacco industry is at fault, yes, I hope they prevail.
Q. Do you hope that the tobacco companies go bankrupt due to judgments they have to pay in litigation brought by plaintiffs?
A. Let me say this: I believe the tobacco industry is responsible for an incredible amount of disease in our country as well as overseas, and whether they go bankrupt or not, I can't tell you or not. I just believe that the product should not be sold; that it is extremely harmful.

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When I'm teaching children and I go into schools, we have five- and six-year-old children, and even younger, starting to use smokeless tobacco, starting to smoke. When you have first graders that are trying to smoke and are smoking on a routine basis, there is something wrong about this.

It is a drug. It contains a drug. It contains thousands of cancer -- thousands of chemicals, several of which are carcinogenic. And I believe that a product that causes cancer, that causes the disease that we see from tobacco should not be sold.

Q. So Doctor --

A. I see that firsthand.

Q. So Doctor, do you hope that the cigarette manufacturers are forced out of business one way or another?

A. I hope that --

MR. YOUNG: Well, I'll object. She just answered, gave you a long answer about that question.

MR. FURR: This is a different question. Go ahead, Doctor.

THE WITNESS: No, it's not.

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MR. YOUNG: You asked about bankruptcy.

THE WITNESS: It's the same thing.

Q. You hope that the cigarette manufacturers are forced out of business.

A. I hope cigarettes and all forms of tobacco will no longer be sold. I think we will have much more money to spend on other things besides dying and individuals who are extremely ill or ill from tobacco-related illnesses; we can spend it on education, on the environment, on a number of other areas that are hurting because we're spending over $60 billion a year on tobacco-related illnesses. And that doesn't include the work lost and the horrible heartache that occurs from families.

Q. Do you hope that the plaintiff in this case, Mrs. Wiley's estate, recovers a judgment against the tobacco companies?

A. I have no interest in the money. My interest -- and I am not being paid for any of this. I mean, I have not asked for one cent. My interest is the fact that I'm a physician, that I see the harm that's caused and the pain, the misery, and the loss.

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Do I hope that they win? Yes. Is there a judgment involved? Monetary judgment? It doesn't matter to me whether it's monetary or not.

Q. You don't care one way or another whether or not the plaintiff in this --

A. I care --

Q. May I finish my question, please, Doctor?

A. Yes, I'm sorry.

Q. I try not to interrupt you.

Is it your testimony, then, you just don't care one way or another whether the jury in this case awards the plaintiff any money?

A. Let me say this -- and then that's just from a clinical standpoint. I think if Mr. Wiley feels that he -- I mean, that's really up to Mr. Wiley to state, not me to state. I mean, it's not -- you know, my point in this, and you could ask a number of individuals, I do a lot of work trying to educate the public on both this as well as head injuries as well as alcohol as well as a number of things, and most of the time I

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do that free of charge. I spend hours doing that, because I'm a physician.

Do I care whether there's monetary? I think that's up to Mr. Wiley. It's not my say.

Q. Well, Doctor, we all know it's not your say as to whether Mr. Wiley recovers any money.

A. Yes.

Q. My only question is, do you care one way or another whether Mr. Wiley recovers any money in this case?

A. If it means that, if they -- when he wins, or if he wins, if that makes people sit up and listen and drives home the point that -- that secondhand smoke and the tobacco industry are liable, if in the public's interest, and what the public sees, that a monetary settlement helps that, then that's fine.

The most important thing, I think, is for the culpability to fall where it should for her illness.

Q. Doctor, you mean that the most important thing to you is that the tobacco companies get punished for her illness?

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MR. YOUNG: I'll object. Asked and answered.
A. Punished? Or -- I think what I'm saying to you is, the fact that if a tobacco industry -- and I believe it did -- caused her illness because there was secondhand smoke, that the public was not educated adequately, that there was not -- things were hidden, that this patient was exposed when she did not have to be, that it's -- that the -- that the tobacco industry be held liable for that.
Now, liability, I mean, is that punishment or is that just responsibility? I believe that they're responsible for her death, as they are a number of deaths, and I think they should be held to that criteria.
MR. FURR: That's all I have.
MR. OHLEMEYER: I have one question, Doctor.
MR. YOUNG: Now, you already stopped.
DIRECT EXAMINATION CONTINUING
BY MR. OHLEMEYER:
Q. Do you think the VA has any responsibility

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for Mrs. Wiley's death?
A. I think the VA has, now that they know, and some of the studies and some of the educational things have gone out there, they no longer allow smoking in their wards.
Q. My question to you, Doctor, is do you think the VA has any responsibility for what happened to Mrs. Wiley?
MR. YOUNG: Well, I object to your question and any further questions. You already took your turn while Jeff was trying to do his notes. You said you were done.
MR. OHLEMEYER: Mr. Young --
MR. YOUNG: Mike, just let me finish, will you?
MR. OHLEMEYER: Let the witness finish. Make your speech. Make your speech. I'm not leaving till the witness answers the question.
MR. YOUNG: I'm going to advise -- I'm not going to advise the witness of anything. I'm going to inform the witness that she's done if she wants to be done. She's to make her own decision about that. But you're the one that said you were done.

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Q. My question to you, Doctor, arises out of the answer you gave Mr. Furr. Do you think the VA has any responsibility for Mrs. Wiley's lung cancer?
THE WITNESS: Do I need to answer this? Yes? No?
MR. YOUNG: Totally up to you, Doctor.
A. Do I think the VA is liable --
Q. Do you think the VA has any responsibility for what happened to Mrs. Wiley?
A. Responsibility for the lung cancer. Well, the question is, I mean, this was -- the question is, is the VA responsible.
Q. That wasn't the question. The question was do you think the VA should bear any responsibility --
A. Responsibility.
Q. -- for what happened to Mrs. Wiley.
A. I think the VA Hospital is -- I think because of what the tobacco industry has done and how they've hidden some things that have occurred, and what the public has been informed of and the educational process that has occurred, I think that the VA now is

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stating that they no longer allow smoking in their wards.
You're asking me to state -- are we picking out the VA from everything else?
Q. My question to you, Dr. Turner, is do you think the VA bears any responsibility for what happened to Mrs. Wiley.
A. Did they sell the drug?
Q. My question to you, Doctor, is do you think the VA bears any responsibility for what happened to Mrs. Wiley.
MR. YOUNG: Well, I'll object. It's been asked and answered more than once.
A. I can't answer that. I can't answer that.
Q. Well, do you think the VA is a victim of the tobacco industry?
MR. YOUNG: That's a second question. You said you only had one.
A. I really can't answer that because I think you're asking it out of context. I really do.
Q. You assisted Mr. Wiley in his effort to obtain compensation, his successful effort to obtain compensation from the VA, didn't you?

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A.I wrote down what I felt needed to be wrote down and presented the facts of the case.
MR. YOUNG: That's totally irrelevant.
A.I don't even know -- I have not --
MR. OHLEMEYER: Would you guys just stop interrupting the witness. Just sit down and stop interrupting the witness.
MR. YOUNG: Don't be nasty. Now, we're just trying to keep this fair.
MR. OHLEMEYER: It's late, we're all tired.
MR. YOUNG: Right.
MR. OHLEMEYER: I've asked the witness a question, she's trying to answer it, and you all are trying to tell her she should or shouldn't answer in the middle of her answer.
MR. HOWARD: Well, Bill, you're trying to mislead her.
MR. OHLEMEYER: Oh, that's ridiculous.
MR. HOWARD: Worker's comp. is without fault in the state of Indiana and so that she can't be, by helping him get

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compensation, she can't be assigning fault to the VA.
MR. OHLEMEYER: I haven't asked a word about fault.
(Discussion off the record.)
Q.I'm going to ask one more. I'm going to ask the question one time, Doctor, I want your best answer to this question.
A.Yes.
Q.Do you think the VA bears any responsibility for what happened to Mrs. Wiley while she worked there?
MR. YOUNG: That's been asked and answered.
A.I truthfully -- I truthfully cannot say. Because of what has occurred from the educational standpoint, and what the tobacco industry has done, I cannot say.
Q.That's your answer. Thanks, Doctor.
MR. YOUNG: Thank you.
MR. OHLEMEYER: We're going to substitute a copy of Exhibit 22 for the original Exhibit 22 which is going to stay with the witness.
AND FURTHER DEPONENT SAITH NOT

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STATE OF INDIANA)
)
COUNTY OF MARION)

I, Patrice E. Morrison, RMR/CRR, CSR 93-R-1030, a Notary Public in and for said county and state, do hereby certify that the deponent herein was by me first duly sworn to tell the truth, the whole truth, and nothing but the truth in the aforementioned matter:

That the foregoing deposition was taken on behalf of the Defendants; that said deposition was taken at the time and place heretofore mentioned between the hours of 8:00 a.m. and 6:00 p.m.;

That said deposition was taken down in stenograph notes and afterwards reduced to typewriting under my direction; and that the typewritten transcript is a true record of the testimony given by said deponent;

And thereafter presented to said witness for signature; that this certificate does not purport to acknowledge or verify the signature hereto of the deponent.

I do further certify that I am a disinterested person in this cause of action; that I am not a relative of the attorneys for any of the parties.

IN WITNESS WHEREOF, I have hereunto set my hand

and affixed my notarial seal this 10th day of

November, 1997.

PATRICE E. MORRISON, Notary Public

My commission expires:
September 28, 2001

Job No. 6531

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NOTICE OF DEPOSITION FILING

IN THE DELAWARE COUNTY SUPERIOR COURT
18301-9305-CT-06
CRAIG DUNN and PHILIP WILEY, ET AL
VS. RJR NABISCO HOLDINGS CORP., ET AL

In compliance with Indiana Rules of Procedure, Rules of the Industrial Board, or Federal Rules of Civil Procedure, pursuant to the Indiana Supreme Court Order dated 3-01-86, you are notified of the filing of the following deposition.

NICKI C. TURNER, M.D.

(Date of filing or mailing by certified mail)

cc: James H. Young, Esq
William N. Riley, Esq
P. Gregory Cross, Esq
Max Howard, Esq
Richard D. Wagner, Esq
Jeffrey L. Furr, Esq
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